

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01540

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH:
Carroll
County.....
City or town..... Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 8 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County.....
City or town..... Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1101 Pennsylvania Ave.
(If rural, give LOCATION)

3. (a) FULL NAME

WALTER ADAMS

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife..... Viola Adams

7. Birth date of deceased (mo., day, yr.) March 17, 1920

6.(c) If alive, give age 25 years

8. AGE:	Years	Months	Days	If less than one day
	24	1	3	hrs. min.

9. Birthplace..... Hallifax, Va.
(Town, county, and state)

10. Usual occupation..... Plummer

11. Industry or business..... Unknown

12. Name..... Unknown

13. Birthplace..... Unknown

14. Maiden name..... Carrie Adams

15. Birthplace..... Unknown

16. Informant..... Reuben Hoffman, M. D.

Address..... Henryton, Md.

17. Burial..... Date thereof 2/25/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Mt. Calvary cem.

Location..... A. G. Cemetery

18. Funeral director..... Adolphus Flatstead

Address..... 918 Druid-Hill Ave.

19. 2/20 19 45 Albert R. Swanson

(Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb., 20, 1945, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 12, 1945, to Feb., 20, 1945,

and that I last saw h. im. alive on February 20, 1945.

Immediate cause of death..... Pulmonary Tuberculosis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

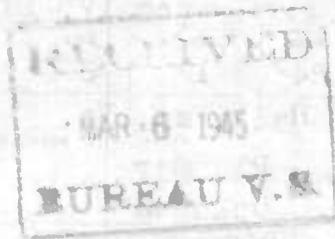
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Reuben Hoffman, M.D. M. D. or other

Address..... Henryton, Md. Date signed 2/20/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 180

01541

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH:
County Carroll

City or town Taneytown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life
Hospital, institution, or street address where death occurred:

How long in hospital or institution? _____

3. (a) FULL NAME

George A. Arnold

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Widowed

6. (b) Name of husband or wife A. Katherine Arnold

7. Birth date of deceased (mo., day, yr.) October 26m 1867

8. AGE: Years	Months	Days	If less than one day
77	3	9	hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Manager

11. Industry or business Grain Warehouse

12. Name Augustine Arnold

13. Birthplace Maryland

14. Maiden name Helen J. Spalding

15. Birthplace Penna.

16. Informant Charles R. Arnold

Address Taneytown, Md.

17. Burial Burial Date thereof 2/1/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Joseph's Cemetery

Location Taneytown, Md.

18. Funeral director C.O. Fuss & Son

Address Taneytown, Md.

19. Feb. 6, 1945 - Ethel M. Wehring
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Taneytown
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (b) Social Security Number

213-12-6487

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4th 1945 at 10:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 27th 1944 to Feb 4th 1945

and that I last saw him alive on Feb 4th 1945

Immediate cause of death Arterio Sclerosa
Stroke an a accident
fall on Oct 27th 1944 stroke
fracturing neck lower left

Other conditions Arterio Sclerosa
stroke
(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of Oct 27th 1944

Where did injury occur Taneytown County Carroll State Md.

Injured at home, farm, industry, public place (where?)

Means of injury slipped fell on floor Kitchen
in bed at work

23. SIGNATURE C. M. Bernier Md

M. D. or other _____ Date signed Feb 5/45

Address Taneytown Md



MAR 2 1965

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13(a)

61542

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

Carroll

County

Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 yrs.

Hospital, institution, or street address where death occurred:

Carroll home of the aged

How long in hospital or institution? 18 yrs.

3. (a) FULL NAME

Margaret W. Baile

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

8. (b) Name of husband or wife.

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

October 8 - 1853

8. AGE:

91

4

20

Days

11 less than one day

hrs.

min.

9. Birthplace

Carroll Co. Md.

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

Lewis T. Baile

MOTHER FATHER

12. Name

Lewis T. Baile

13. Birthplace

Carroll Co. Md.

14. Maiden name

Sarah Ann McAdams

15. Birthplace

Carroll Co. Md.

16. Informant

Carroll home records

Address

Westminster, Md.

17. Burial

Date thereof March 9, 1885
(Burial, cremation, or removal. Which?)

(month)

(day)

(year)

Cemetery or crematory

Pine Creek Cemetery

Location

Wakfield Carroll Co. Md.

18. Funeral director

A. Bankard & Son

Address

Westminster, Md.

19.

31 19 45

(Date rec'd by registrar)

Alwood

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County

Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28

19 45 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Mar. 30, 1944, to Feb. 28, 1945, and that I last saw her alive on Feb. 24, 1945.

Immediate cause of death

Myocardial degeneration 1 yrs.

DURATION

Due to

Chronic interstitial nephritis 6 months

Due to

Other conditions

cancer

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

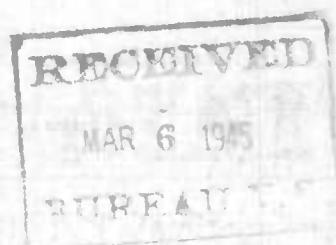
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other
Reesel Wilhens 7/1
Westminster, Md. Date signed 1/1/45



M

MARGIN RESERVED FOR BINDING

I

VS A15 T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

01543

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 63 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Elizabeth C. Barnes

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F. W. Widowed

6. (b) Name of husband or wife

Fev Barnes

7. Birth date of

deceased (mo., day, yr.)

May 11, 1862

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

82 8 22 hrs. min.

9. Birthplace

Carroll Co. Md.

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

MOTHER FATHER

12. Name John Bennett

13. Birthplace England

MOTHER

14. Maiden name Eliza Roberts

15. Birthplace England

FATHER

16. Informant Mrs. Estell Sykesville

Address

Sykesville, Md.

Burial

Cremation

or removal. Which?

Date thereof Feb 4, 1945

(month) (day) (year)

Cemetery or crematory

Springfield Cemetery

Location

Sykesville, Md.

18. Funeral director

C. Harry Wee

Address

Sykesville, Md.

Feb 3

1945

(Date rec'd by registrar)

C. Harry Wee

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

Carroll

City or town

Sykesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

February 2 1945 at 9 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 15 1945 to Feb 2 1945 and that I last saw him alive on Feb 1 1945

Immediate cause of death

Sunstroke

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

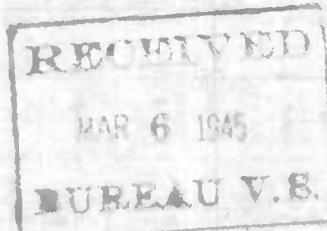
J. Barnes M.D.

M. D. or other

Address

Date signed

Feb 3 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

01544

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: Carroll
 County Carroll
 City or town Lyonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 month, 13 days
 Hospital, Institution, or street address where death occurred: Springfield State Hospital
 How long in hospital or institution? 1 month, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Carrollton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 129 Independence St.
 (If rural, give LOCATION)

3. (a) FULL NAME
JOHN BERLIN

4. Sex <u>male</u>	5. Color or race <u>white</u>	6. (a) Single, married, widowed, or divorced <u>single</u>
--------------------	-------------------------------	--

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) May 6, 1894 8. (c) If alive, give age..... years

8. AGE: Years 50 Months 9 Days 19 If less than one day
 hrs. min. min.

9. Birthplace West Virginia
 (Town, county, and state)

10. Usual occupation Machinist

11. Industry or business Tire Factory

12. Name Arnold Berlin

13. Birthplace W. Va.

14. Maiden name Coro Virtue

15. Birthplace W. Va.

16. Informant Hospital records

Address

17. Burial Burial Date thereof March 1, 1945
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Green Hill Cemetery

Location Martinsburg, W. Va.

18. Funeral director Kogel & Schatz & Coffman

Address Martinsburg, W. Va.

19. Date Feb. 26, 1945 C. Harry Lee
 (Date rec'd by registrar) Registrars

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25, 1945 at 6 1/2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 12, 1945 to February 25, 1945 and that I last saw him alive on February 25, 1945

Immediate cause of death Chronic Myocarditis DURATION Unknown

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

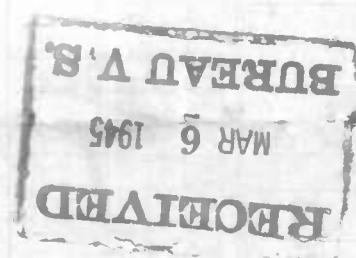
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE Arnold H. Eickert, M.D.
 M. D. or other

Address 1st Hosp., Sykesville, Md. Date signed 2-25-45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

01545

Reg. Dist. No. 81

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County

City or town

Carroll
Rural Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

25 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mrs. Clara L. Bohn

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F

W

married

B. (b) Name of husband or wife

Jesse M. Bohn

7. Birth date of deceased (mo., day, yr.)

Jan 4, 1888

6. (c) If alive, give age years

8. AGE:

Years Months Days If less than one day

57

1

4

hrs.

min.

9. Birthplace

(Town, county, and state)

Hagerstown

10. Usual occupation

Housewife

11. Industry or business

John W. Black

MOTHER FATHER

12. Name

John W. Black

MOTHER FATHER

13. Birthplace

Md

MOTHER FATHER

14. Maiden name

L. Anna Blantz

MOTHER FATHER

15. Birthplace

Md

MOTHER FATHER

16. Informant

Jesse M. Bohn

MOTHER FATHER

Address

Union Bridge, Md.

MOTHER FATHER

17. Burial

Date thereof

(month) (day) (year)

MOTHER FATHER

(Burial, cremation, or removal, which?)

MOTHER FATHER

Cemetery or crematory

Berea Dam

MOTHER FATHER

Location

Md Union Bridge, Md.

MOTHER FATHER

18. Funeral director

O'Donnell

MOTHER FATHER

Address

Janeytown, Md.

MOTHER FATHER

19. Date rec'd by registrar

Feb 10 1955

(Date rec'd by registrar)

Signature

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md. County Carroll

City or town

Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

woman

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 9 1955 at 9:45

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 6 1945 to Feb 9 1955

and that I last saw her alive on Feb 9 1955

Immediate cause of death

Carcinomatous Breast

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

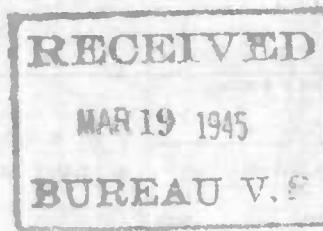
Means of injury

Injured at work?

23. SIGNATURE

J. H. Legg M. D. or other

Address Union Bridge Date signed 2-9-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

01546

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County, *Garrett*City or town, *Westminster Rd.*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *3 yrs*

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

*Mrs. Annie E Brown*4. Sex *F* 5. Color or race *W* 6. (a) Single, married, widowed, or divorced *widowed*6. (b) Name of husband or wife *John H Brown*7. Birth date of deceased (mo., day, yr.) *Oct 14, 1871*6. (c) If alive, give age *80* years8. AGE: Years *73* Months *4* Days *14* If less than one dayhrs. *0* min. *0*9. Birthplace *Md.*

(Town, county, and state)

10. Usual occupation *Housewife*11. Industry or business *Aaron Hiltzbridge*12. Name *Aaron Hiltzbridge*13. Birthplace *Md.*14. Maiden name *Ellen Formwalt*15. Birthplace *Md.*16. Informant *Mrs Walter Shatto*Address *Westminster Rd.*17. Burial (Burial, cremation, or removal, when?) *Burial*Date thereof *Mar 3, 1945*

(month) (day) (year)

Cemetery or crematory *Graves*Location *near Westminster, Md.*18. Funeral director *Ed. Bassett*Address *Tanytown, Md.*19. (Date read by registrar) *3/3/45*Registrar *Glwood*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State, *Md.*County, *Carroll*City or town, *Rural Westminster*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *1 Sullivan Road*

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH *February 28, 1945* at *7 P.M.*21. I CERTIFY that death occurred on the date above stated: that I attended deceased from *and 2nd* *1943* to *Feb 28, 1945*and that I last saw her alive on *February 22, 1945*Immediate cause of death *acute cardiac*or *arteriosclerosis* -DURATION *5 minutes*Due to *chronic myocarditis* *4 yrs*Due to *arteriosclerosis* *5 yrs*

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?

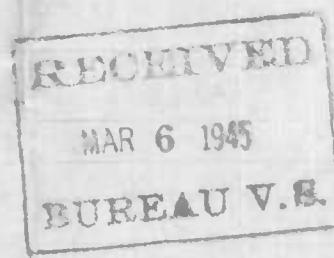
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

13. SIGNATURE *Elas R. Forty* M.D.M. D. or other *Westminster, Md.*Address *Westminster, Md.* Date signed *3/3/45*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01547

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County..... Carroll
City or town..... Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs., 3 mo., 15 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland
County.....
City or town..... Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No..... 1609 Druid Hill Ave.
(If rural, give LOCATION) ✓

3. (a) FULL NAME

LEONARD BUTLER

3. (b) Social Security Number
216-10-1547

4. Sex male 5. Color or race colored 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife..... Lillian Butler

6.(c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.) August 13, 1919

8. AGE: Years 25 Months 5 Days 28 If less than one day hrs. min.

9. Birthplace..... Baltimore, Md.
(Town, county, and state)

10. Usual occupation..... Porter

11. Industry or business

12. Name..... Elisha Butler
13. Birthplace..... Baltimore, Maryland

14. Maiden name..... Otelia Brown

15. Birthplace..... St. Mary's County, Md.

16. Informant..... Reuben Hoffman, M.D.

Address..... Henryton, Maryland

17. Burial
(Burial, cremation, or removal. Which?) Date thereof..... Feb 14 1945
(month) (day) (year)

Cemetery or crematory..... Arbutus Memorial Park

Location.....

18. Funeral director..... Mrs. George W. Stalla

Address..... 1631 Druid Hill Ave.

19. Feb. 10, 1945 Albert R. Seaman, M.D.
(Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 10, 1945 at 4:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 26, 1942, to February 10, 1945,

and that I last saw h. im. alive on February 10, 1945.

Immediate cause of death

Tuberculosis of Spine

DURATION
March 1940

Due to.....

Due to.....

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE..... Reuben Hoffman, M.D.

M. D. or other
Address..... Henryton, Md. Date signed..... 2-10-45

RECEIVED

FEB 21 1945

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CERTIFICATE OF DEATH

01548

74

Reg. Dist. No.....

1. PLACE OF DEATH:
Carroll
County.....

Henryton
City or town.....

(If outside city or town limits, write RURAL and give nearest town)

22 days

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

Maryland County..... Montgomery

Gaithersburg
City or town.....

(If outside city or town limits, write RURAL and give nearest town)

R. R. #2
Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

VERNON BUTLER

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)
March 6, 1900

8. AGE: Years	Months	Days	If less than one day
44	10	27	hrs. min.

9. Birthplace..... Gaithersburg, Md.
(Town, county, and state)

10. Usual occupation..... Farm worker

11. Industry or business

12. Name..... Mansfield Butler

13. Birthplace..... Montgomery County, Md.

14. Maiden name..... Elizabeth Weeks

15. Birthplace..... Montgomery County, Md.

16. Informant..... Reuben Hoffman, M.D.

Address..... Henryton, Maryland

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof..... Apr. 6/1943
(month) (day) (year)

Cemetery or crematory..... Brookside Cemetery

Location..... Gaithersburg, Montgomery

18. Funeral director..... Roy W. Barr

Address..... Columbia 22

19. Feb. 2, 1945 Albert R. Swank
(Date rec'd by registrar) Deputy Local Registrar

3. (b) Social Security Number
218-16-0325

MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 2, 1945 at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
January 11, 1945, to Feb. 2, 1945

and that I last saw him alive on February 2, 1945

Immediate cause of death.....
Lymphoma (Mediastinal glands) DURATION
7-30-43

Due to.....

Due to.....

Other conditions..... Pulmonary tuberculosis
(Include pregnancy within 3 months of death) 4-2-43

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

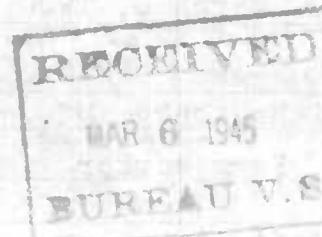
Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Reuben Hoffman, M.D.
M. D. or other
Address..... Henryton, Md. Date signed..... 2-2-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 20

CERTIFICATE OF DEATH

01549

Reg. Dist. No. 74

1. PLACE OF DEATH: Rural Carroll
 County Carroll
 City or town rural near Sykesville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 11 yr. 6 mo. 3 days
 Hospital, Institution, or street address where death occurred: Springfield State Hospital
 How long in hospital or institution? 11 yr. 6 mo. 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Maryland County Washington
 City or town Williamsport
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Samuel Floyd Charlton

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced
Married
 6.(b) Name of husband or wife Minnie
 7. Birth date of deceased (mo., day, yr.) December 5, 1880 6.(c) If alive, give age _____ years
 8. AGE: Years 64 Months 2 Days 1 If less than one day
hrs.min.

8. Birthplace Harrisonburg, Virginia
 (Town, county, and state)
 10. Usual occupation Plasterer
 11. Industry or business
 FATHER 12. Name Jasper Charlton
 MOTHER 13. Birthplace Virginia
 14. Maiden name Mattie
 15. Birthplace Virginia
 16. Informant Springfield State Hosp. records
 Address Sykesville, Maryland

17. Burial Date thereof 2/11/1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Williamsport
 Location Williamsport, Maryland
 18. Funeral director Edith S. Leaf
 Address Williamsport, Maryland
 19. Feb. 9, 1945 C. Harry Green
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6 1945 5:15 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943 to Feb. 6 1945and that I last saw him alive on February 4 1945.Immediate cause of death General paralysis of the insane DURATION 14 yrs.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings or operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

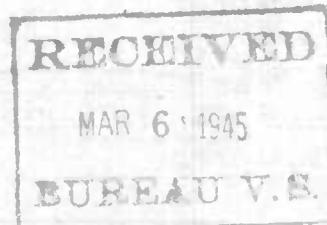
Injured at home, farm, industry, public place (where?)

Means of injury _____

Injured at work? _____

Robert Bertrand May, M.D.

23. SIGNATURE Robert Bertrand May, M.D. M.D. or otherSpringfield State Hospital Address Williamsport, Maryland Date signed 2-6-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01550

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

Carroll County

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yrs., 1 month, 1 day

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 8 yrs., 1 month, 1 day

3. (a) FULL NAME

Thomas Clemens

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Not known

6. (b) Name of husband or wife

Not known

7. Birth date of deceased (mo., day, yr.)

1877?

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

68?

?

?

hrs. min.

9. Birthplace

Not known

(Town, county, and state)

10. Usual occupation

Not known

11. Industry or business

FATHER

Not known

MOTHER

Not known

14. Maiden name

Not known

15. Birthplace

Not known

16. Informant

Records of Springfield State

Address

Hospital, Sykesville, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Feb. 8, 1945
(month) (day) (year)

Cemetery or crematory

Springfield Hosp. Cem.

Location

Sykesville, Md.

18. Funeral director

C. Harry Weer

Address

Sykesville, Md.

19. (Date rec'd by registrar)

1945

(Date rec'd by registrar)

C. Harry Weer

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 821 Shakespeare Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6

19 45 4:10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 6 1937 to Feb. 6 1945

and that I last saw h. 1m. alive on Feb. 5 1945

Immediate cause of death

Peritonitis

DURATION

1 day

Due to Rupture of Gall-Bladder

3 days

Due to

Other conditions Pulmonary Tuberculosis

1937

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, Industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

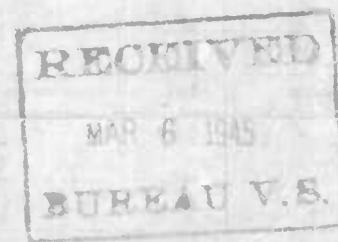
M. Virginia Beyer

M.D. or other

Sykesville, Md.

Feb. 6-45

Date signed



M

Evidence for change of
birthdate shown on Film G92
3/3/45 dm

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01551

75

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Carroll
County: Rural Manchester, Md.
City or town: Rural Manchester, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days
Hospital, Institution, or street address where death occurred:

How long in hospital or institution? _____

3. (a) FULL NAME Charles Marshall Covelly

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

B. (c) Name of husband or wife Beulah Covelly

7. Birth date of deceased (mo., day, yr.) September 14, 1890 8. (c) If alive, give age 40 years

8. AGE: Years 54 Months 5 Days 3 If less than one day _____ hrs. _____ min.

9. Birthplace Portland, Maine
(Town, county, and state)

10. Usual occupation Bricklayer

11. Industry or business Unknown

MOTHER FATHER

12. Name Unknown

13. Birthplace "

14. Maiden name Unknown

15. Birthplace "

16. Informant Mrs. Beulah Covelly

Address 6204 Birchwood Ave

17. Buried Date thereof Feb. 22 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Parkwood

Location Baltimore Co. Parkville

18. Funeral director J. Leonard Ruck

Address 5300 Harford Rd. Baltimore, Md.

19. Date rec'd by registrar Feb. 18 1945 Mrs. H. R. S. Garner

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State Maryland County Baltimore City
City or town Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6204 Birchwood Ave
(If rural, give LOCATION)

2. (a) If veteran, name war World War I

3. (b) Social Security Number

217-07-5466

MEDICAL CERTIFICATION

20. DATE OF DEATH February 18 1945 at 3:47 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 18 1945 to February 18 1945and that I last saw h. alive on February 18 1945Immediate cause of death Cerebral hemorrhageDURATION 16 hoursDue to HypertensionDue to chronic nephritis?

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

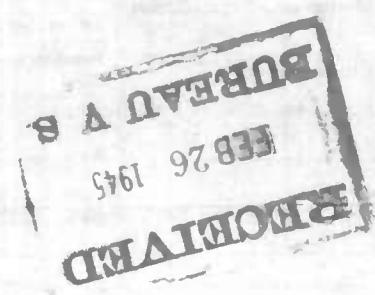
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE L. V. Sobel, M.D.M. D. or other MDAddress Manchester, Md. Date signed Feb. 18 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2

01552

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: Carroll
County
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 months, 7 days
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 10 months, 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME
Elmer Crowe

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Adeline

7. Birth date of deceased (mo., day, yr.) August 1, 1898
8.(c) If alive, give age: years

8. AGE: Years	Months	Days	If less than one day
46	6	25	hrs. min.

9. Birthplace: Garrett County, Maryland
(Town, county, and state)

10. Usual occupation: Fish

11. Industry or business: Silas Crowe

MOTHER FATHER
12. Name: Silas Crowe
13. Birthplace: York

MOTHER
14. Maiden name: Mary
15. Birthplace: York

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial
(Burial, cremation, or removal. Which?) Date thereof: May 1, 1945
(month) (day) (year)

Cemetery or crematory: Cumberland
Location: Allegany Co., Md.

18. Funeral director: C. Harry Lee
Address: Sykesville, Md.

19. Date rec'd by registrar: May 3, 1945
(Date rec'd by registrar) C. Harry Lee
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 26 1945 at 4:25 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 26 1944 to Feb. 26 1945 and that I last saw him alive on February 25 1945.

Immediate cause of death: Chronic valvular heart disease, prior to Streptococcus viridans endocarditis

Due to: Bulbar paralysis, etiology unknown

Due to: Adhesive pericarditis

Other conditions: Undiagnosed psychosis

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

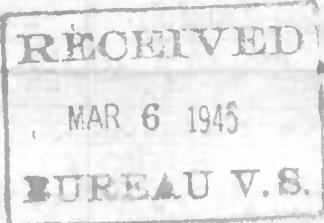
Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
Springfield State Hospital M. D. or other

Address: Sykesville, Maryland Date signed: 2-26-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01553

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 yrs 8 mo 26 days

Hospital, Institution, or street address where death occurred:

Springfield St. Hospital

How long in Hospital or Institution? 21 yrs 8 mo 26 days

3. (a) FULL NAME

Female white Widowed

6. (b) Name of husband or wife Keith D. Dorman

7. Birth date of deceased (mo., day, yr.) (up to day unknown) 1891

8. AGE: Years Months Days If less than one day hrs. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Thompson

13. Birthplace Boston and Friends

MOTHER 14. Maiden name Thompson

15. Birthplace Boston and Friends

16. Informant Hospital

Address Sykesville, Md.

17. Burial Date thereof Feb. 24, 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Joseph's Cem.

Location Boston, Mass.

18. Funeral director C. Harry Wee

Address Sykesville, Md.

19. Feb. 20, 1945 C. Harry Wee

(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Bel Air (If outside city or town limits, write RURAL and give nearest town)

Street No. 3436 Bel Air Road (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH February 18th 1945, at 5 A.M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 23rd 1944 to Feb. 17, 1945, and that I last saw her alive on Feb. 17, 1945.

Immediate cause of death

Hypertension or Cerebral Vascular Disease

Due to

Due to

Hypertension or Cerebral Vascular Disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

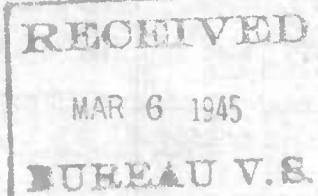
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Grand M. Ross M.D.

M. D. or other

Address Sykesville, Md. Date signed 2-18-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 182

11554

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: Carroll

County.....

City or town..... rural near Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 26 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 3 months, 26 days

3. (a) FULL NAME

George Scott Drill

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

white

widowed

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

October 3, 1866

8. AGE:

Years

Months

Days

If less than one day

78

4

22

hrs.

min.

9. Birthplace

Boonsboro - Wash. - Md.

(Town, county, and state)

10. Usual occupation.

Night Watchman

11. Industry or business

Henry Drill

Boonsboro, Md.

12. Name

Henry Drill

Boonsboro, Md.

13. Birthplace

Boonsboro, Md.

14. Maiden name

Ziegler

15. Birthplace

Boonsboro, Md.

16. Informant

Springfield State Hosp. records

Address

Sykesville, Maryland

17. Burial

(Burial, cremation, or removal, which?)

Date thereof Feb 28-45

(month) (day) (year)

Cemetery or crematory

Rose Hill

Location

Hagerstown, Md.

18. Funeral director

Fred W. Krazes

Address

Hagerstown, Md.

19. Date rec'd by registrar

Feb 26 1945

C. Harry Steel

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County..... Washington

City or town..... Hagerstown, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 325 Mulberry St.

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

212-14-7172

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25 1945 at 11:00 p.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 30 1944 to Feb. 25 1945

and that I last saw him alive on February 25 1945

Immediate cause of death.....

Senility

DURATION

3 years

Due to.....

Due to.....

Senile psychosis,
simple deterioration

3 years

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

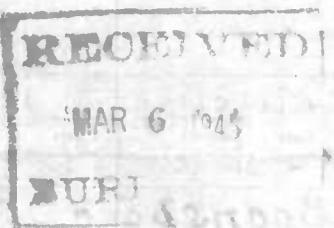
Robert Bertrand May, M.D.

Robert Bertrand May, M.D.

Springfield State Hospital M. D. or other

Sykesville, Maryland Date signed 2-26-45

Address.....



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

01555

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: Carroll

County

Near Eldersburg

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Frederick Dutton

4. Sex

Male Colored MARRIED

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

Nancy Dutton

7. Birth date of

deceased (mo., day, yr.)

Unknown

6.(c) If alive, give age 95 years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Carroll Co. Maryland

(Town, county, and state)

None

10. Usual occupation

11. Industry or business

FATHER

Frederick Dutton

13. Birthplace

Maryland

MOTHER

Nancy Reubottom

15. Birthplace

Maryland

18. Informant

Nancy Dutton

Address

Burial Date thereof 2-21-45

(Burial, cremation, or removal) (month) (day) (year)

Cemetery or crematory

White Rock

Location

Bennett Carroll Co. Md

16. Funeral director

G. M. Wall

Address

Whitfield, Md

17. Feb. 20 1945

(Date rec'd by registrar)

C. Harry Dyer

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

County

Carroll

City or town

Burr - Golding

Street No.

P. O. Sykesville

(If outside city or town limits, write RURAL and give nearest town)

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Feb 17 1945 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw him alive on 19.

Immediate cause of death

Generalized arteriosclerosis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

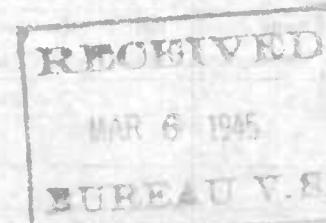
Sergeant, Maryland State Police, Examiner

New Oldendorf Md

M. D. or other

Date signed 2/7/45

RECEIVED TO PENNSYLVANIA STATE CHARTER



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 15-6

01556

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 21 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Cecil
City or town Cecilton
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

3. (a) FULL NAME

HELEN EMORY

4. Sex <u>Female</u>	5. Color or race <u>Colored</u>	6.(a) Single, married, widowed, or divorced <u>Single</u>
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6.(b) Name of husband or wife.....

6.(c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.) May 6, 1923

8. AGE: Years <u>21</u>	Months <u>9</u>	Days <u>17</u>	If less than one dayhrs.min.
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9. Birthplace Cecilton, Md.
(Town, county, and state)10. Usual occupation Domestic

11. Industry or business

12. Name <u>William Emory</u>
13. Birthplace <u>Maryland</u>
14. Maiden name <u>Arrie Sewell</u>
15. Birthplace <u>Maryland</u>

16. Informant Reuber Hoffman, M. D.
Address Henryton, Md.

17. Burial Date thereof Feb. 28 - 1945
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Cecilton Cemetery
Location Cecilton, Md.

18. Funeral director S. W. Chase Sons
Address 536 N. Gulmore St.

19. 2/23 19 45 Albert Seawright Registrar
(Date rec'd by registrar) (Date of death) (Name of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 23, 1945 at 10.20 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 2, 1945 to Feb. 23, 1945and that I last saw him alive on February 23, 1945.

Immediate cause of death

Pulmonary Tuberculosis

DURATION
August 1944

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

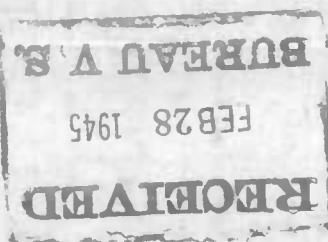
Means of injury

Injured at work?

23. SIGNATURE Reuber Hoffman, M. D.

M. D. or other

Address Henryton, Md.Date signed 2/23/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

01557

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County CARROLLCity or town WESTMINSTER

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

EVERETT HOPKINS GAREY

4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced MARRIEDB.(b) Name of husband or wife HELEN M. BROWN7. Birth date of deceased (mo., day, yr.) DECEMBER 31, 1891 6.(c) If alive, give age 50 years8. AGE: Years 53 Months 2 Days 23 If less than one day hrs. min.9. Birthplace DENTON, MD. (Town, county, and state)10. Usual occupation DENTIST

11. Industry or business

12. Name THOMAS F. GAREY13. Birthplace MD.14. Maiden name ANNA DIXON15. Birthplace MD.16. Informant MRS. E. H. GAREYAddress WESTMINSTER, MD.17. BURIAL Date thereof 2/24/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory BALTIMORE NATIONAL CEM.Location BALTIMORE, MD.18. Funeral director J. FRANCIS REESEAddress WESTMINSTER, MD.19. 2/23/45 J. Francis Reese
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County CARROLLCity or town WESTMINSTER (If outside city or town limits, write RURAL and give nearest town)Street No. 13 W. MAIN ST. (If rural, give LOCATION)2.(a) If veteran, name war WORLD WAR I

3. (b) Social Security Number

None

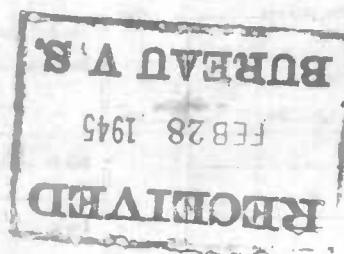
MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 23 1945, at 6 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 10 1945, to February 23 1945, and that I last saw him alive on February 25 1945.Immediate cause of death Acute Hemiplegia DURATION 24 hrs.Due to Myocardial Infarction 1 yearDue to Arterio-Sclerotic, General 5 yearsOther conditions (Include pregnancy within 8 months of death)Major findings of operations Date of op.Autopsy results Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date ofWhere did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?)Means of injury Injured at work?23. SIGNATURE John Bon M. D. or otherAddress WESTMINSTER, MD. Date signed 2/23/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 31-2

01558

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH:

County Carroll

City or town Janes Town P.D. (Janes Town Dist.)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Enoch David Fealy

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Widowed

6. (b) Name of husband or wife

Sarah Fealy

7. Birth date of deceased (mo., day, yr.)

Aug. 22 - 1855

6. (c) If alive, give age Dead years

8. AGE:

Years

Months

Days

If less than one day

89

5

27

hrs. min.

9. Birthplace

Adams Co. PA

(Town, county, and state)

10. Usual occupation

Retired Farmer

11. Industry or business

Farm

MOTHER FATHER

12. Name

Jacob Fealy

13. Birthplace

France

14. Maiden name

Rebecca Wolfe

15. Birthplace

Adams Co. PA

16. Informant

Ralph Fealy

Address

Westminster, Md

17. Burial

Date thereof Feb. 22-1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or columbarium

St. John's Cemetery

Location

Littlestown, PA

18. Funeral director

J. W. Little & Son

Address

Littlestown, PA P. O. R. A. L.

19. H. H. S. 1945

Date rec'd by registrar

Local

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State P.A.

County

Adams

City or town Littlestown, P.D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 19 1945 at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 23 1944 to Feb. 19 1945

and that I last saw him alive on Feb. 19 1945

Immediate cause of death

Chronic Myocarditis and myocardial degeneration - not Rheumatic.

Due to Chronic Hypertension + Tramia

DURATION

25 yrs.

Due to Hypertrophy of the prostate 15 yrs.

20 yrs.

Other conditions Benignoid Arteriosclerosis.

15 yrs.

(Include pregnancy within 3 months of death)

Major findings or operations

None

Date of op.

Autopsy results

Not Done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

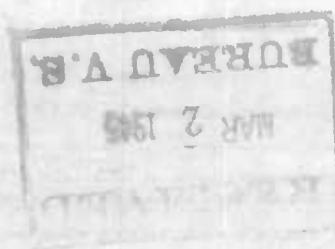
Means of injury

Injured at work?

23. SIGNATURE R. S. McVaugh, M.D.

M. D. or other

Address Taneytown, Md. Date signed 2/20/45



Evidence for change of
age of deceased is shown on
FILM NO. G 94 APR 13 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 469 ✓

01559

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs. 6 mon. 1/2 day

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 3 yrs. 6 mon. 1/2 day

3. (a) FULL NAME

John Edward Geckle

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Aug. (?) 18-26 1875

6. (c) If alive, give age years

8. AGE: Years 69 Months 6 Days If less than one day hrs. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation Bristle comb

11. Industry or business

12. Name Charles Geckle

13. Birthplace Germany

14. Maiden name

15. Birthplace Germany

16. Informant Mrs. Mary E. Kelso, sister

Address 1140 Montpelier St., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 23, 1945

(month) (day) (year)

Cemetery or crematory Holy Redeemer Cem.

Location Balto. Md.

18. Funeral director William Cook Inc.

Address 1217 St. Paul St.

19. Date rec'd by registrar Feb. 20, 1945

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH February 20 1945 at 11 40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 14 1945, to Feb. 20 1945

and that I last saw him alive on Feb. 20 1945

Immediate cause of death

Carcinoma of head of pancreas

DURATION

one week

Due to

Due to

Other conditions

Psychosis & Cerebral arterioSclerosis

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

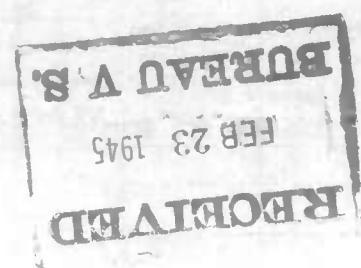
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Sykesville, Md. Date signed 2-20-45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01560

CERTIFICATE OF DEATH

74

Reg. Diat. No.

M
 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
Carroll
County.....

City or town..... Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 4 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium

Colored Branch, Henryton, Maryland

How long in hospital or institution?.....

3. (a) FULL NAME

JAMES CARDINAL GRAY

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced
male col. married

8. (b) Name of husband or wife..... Clara Gray

7. Birth date of deceased (mo., day, yr.)..... August 27, 1908
..... years

8. AGE: Tears Months Days If less than one day
36 5 30 hrs. min.

9. Birthplace..... Hughesville, Md.
(Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business

12. Name..... Timothy Gray
13. Birthplace..... Unknown

14. Maiden name..... Dalphine Wright

15. Birthplace..... Maryland

16. Informant..... Reuben Hoffman, M.D.
Address..... Henryton, Maryland

17. Burial..... Date thereof..... 3/11/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... St. Philip's Church Cem.
Location..... Agassiz Rd., Henryton, Md.

18. Funeral director..... George C. Price
Address..... Agassiz Rd., Henryton, Md.

19. Feb. 26, 1945
(Date rec'd by registrar) 45 Deputy Local Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County..... Prince Georges

City or town..... Brandywine
(If outside city or town limits, write RURAL and give nearest town)

Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number
none

MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 26, 1945, at 2:00 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 22, 1945, to Feb. 26, 1945, and that I last saw him alive on February 26, 1945.

Immediate cause of death.....

Pulmonary Tuberculosis

DURATION

Dec. 1944

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

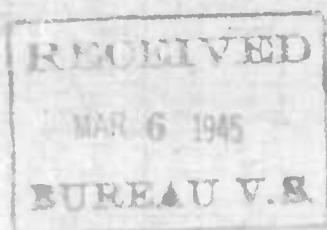
Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE..... Reuben Hoffman, M.D.
M. D. or other

Address..... Henryton, Md. Date signed..... 2-26-45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-6

CERTIFICATE OF DEATH

Reg. Dist. No. 74

01561

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

1 MARGIN RESERVED FOR BINDING

2

VS A15

1. PLACE OF DEATH:
Carroll County

City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 24 days

Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium

Colored Branch, Henryton, Maryland.
How long in hospital or institution?

3. (a) FULL NAME
AMELIA JULIA GREEN

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	colored	single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Aug., 16, 1912
.....(c) If alive, give age years

8. AGE: Years	Months	Days	If less than one day
32	5	25	hrs. min.

9. Birthplace Savannah, Ga.
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business Wesley Williams

FATHER 12. Name Savannah, Ga.

MOTHER 13. Birthplace Annie Hughes

14. Maiden name Savannah, Ga.

15. Birthplace Reuben Hoffman, M. D.

16. Informant Henryton, Maryland.

Address

17. (Burial, cremation, or removal. Which) Date thereof Feb. 12, 1945
(month) (day) (year)

Cemetery or crematory Mt. Auburn Cem.

Location Baltimore

18. Funeral director Mrs. Katie P. Williams

Address 322 N. Schreeder St.

19. 2/8 1945

(Date rec'd by registrar) Deputy Local

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1709 Cario Street
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number
none

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8, 1945, at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 15, 1944, to Feb. 8, 1945, and that I last saw her alive on February 8, 1945.

Immediate cause of death Pulmonary Tuberculosis

DURATION
March 1943

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

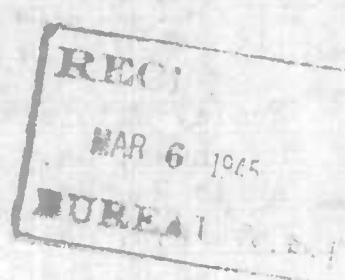
Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman, M.D.

M. D. or other

Date signed 2/8/45

Address Henryton, Md.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01562

CERTIFICATE OF DEATH

74

Reg. Dist. No.

1. PLACE OF DEATH: Carroll
County.....
City or town..... Henryton, (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year, 6 mo., 22 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County.....
City or town..... Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No..... 531 N. Bond Street (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

3. (a) FULL NAME

BURRELL GREEN

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife..... Sarah Green

7. Birth date of deceased (mo., day, yr.) April 25, 1895

8. AGE: Years	Months	Days	If less than one day
49	9	17	hrs. min.

9. Birthplace..... Homewood, Virginia
(Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business.....

12. Name..... General Green

13. Birthplace..... Unknown

14. Maiden name..... Mattie Brodnax

15. Birthplace..... Unknown

16. Informant..... Reuben Hoffman, M.D.

Address..... Henryton, Maryland

17. (Burial, cremation, or removal. Which?) Date thereof: Feb. 15th / 45
(month) (day) (year)

Cemetery or crematory..... Mt. Calvary Cemetery

Location..... Brookland Md.

18. Funeral director..... Oliver Wilson

Address..... 1000 Bryant St.

19. Feb. 11, 1945

(Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 11, 1945, at 11:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

July 20, 1943, to Feb. 11, 1945, and that I last saw him alive on February 11, 1945.

Immediate cause of death..... Pulmonary Tuberculosis

DURATION

Jan. 1943

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?.....

23. SIGNATURE..... Reuben Hoffman, M.D. M. D. or other

Address..... Henryton, Md. Date signed..... 2-11-45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Mo.*

CERTIFICATE OF DEATH

01563

Reg. Dist. No.

76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County *Carroll Co.*City or town *near Synder* *Rural*

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or Inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) *about 3 years*

3. (a) FULL NAME

*MARY U. HANSON*4. Sex *f.*5. Color or race *W.*6. (a) Single, married, widowed, or divorced *Married*6. (b) Name of husband or wife *Charles W. Hanson*

7. Birth date of deceased (mo., day, yr.)

*not known*6(c) If alive, give age *55* years

8. AGE: Years

Months

Days

If less than one day

about 59

hrs.

min.

9. Birthplace *West Va., Greenbrier Co.*

(Town, county, and state)

10. Usual occupation *House-wife*

11. Industry or business

12. Name *Wallace Crookshanks*13. Birthplace *W. Va.*14. Maiden name *Isabelle Hayslette*15. Birthplace *West Va.*16. Informant *Charles W. Hanson*Address *Spencerville Rd, Md.*

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof *3/3/45* (month) (day) (year)Cemetery or crematory *James Chapel*Location *Clintonville, Greenbrier Co. W. Va.*18. Funeral director *J. E. Myers, Jr.*Address *West Virginia, Md.*19. (Date rec'd by registrar) *2/27/45*Signature *J. E. Myers, Jr.*

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.*County *Carroll Co.*City or town *near Synder*

Ward No.

Street No. *near Synder, 10 miles south of Synder*

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH *Feb 26, 1945* 19 *at 8A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-14-45 19 to *2-26-45* 19and that I last saw her alive on *2-23-45* 19

Immediate cause of death

Coronary Thrombosis

DURATION

10 hr.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings

Of operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work

23. SIGNATURE *J. E. Myers, Jr.*

M. D. or other

Address *Reisterstown, Md.*Date signed *2/26/45*

RECEIVED

MAR 6 1945

BUREAU V.E.

M

MARGIN RESERVED FOR BINDING

1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01564

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: Carroll
 County.....
 City or town..... rural near Sykesville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 15 yr., 8 mo., 24 days
 Hospital, institution, or street address where death occurred: Springfield State Hospital
 How long in hospital or institution? 15 yr., 8 mo., 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State..... Maryland County.....
 City or town..... Baltimore City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)

3. (a) FULL NAME
 Joseph B. Harrison

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) May 1, 1891 6.(c) If alive, give age..... years

8. AGE: Years 53 Months 9 Days 3 If less than one day hrs. min.

9. Birthplace..... Baltimore City, Maryland

(Town, county, and state)

10. Usual occupation..... Optician & optometrist

11. Industry or business..... Optical

12. Name..... George Harrison

13. Birthplace..... St. Mary's County, Maryland

14. Maiden name..... Mary A. Brooks

15. Birthplace..... Allegany County, Maryland

16. Informant..... Springfield State Hosp. records

Address..... Sykesville, Maryland

17. Burial..... Date thereof..... 2-7-45.
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... New Cathedral Cem.

Location..... 4300 Old Frederick Rd.

18. Funeral director..... L. H. S. F. Evans & Son

Address..... 118 W. Mt. Royal Ave.

19. Feb. 11 1945 C. H. Keay, Registrar
 (Date rec'd by registrar)

2. (a) If veteran, name war.....
 3. (b) Social Security Number..... none

MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 4 1945 at 10:50a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943 to Feb. 4 1945 and that I last saw him alive on February 4 1945.

Immediate cause of death..... Chronic endocarditis (valvular heart disease) DURATION..... 35 yr.

Due to.....

Due to.....

Other conditions..... Dementia precox, hebephrenic type (Include pregnancy within 3 months of death) 21 yrs.

Major findings or operations..... Date of op.

Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

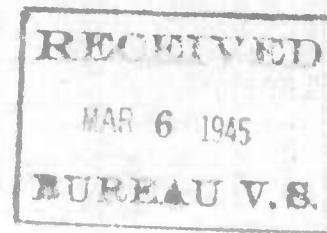
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE..... Robert Bertrand May, M.D. or other

Springfield State Hospital Address..... Sykesville, Maryland Date signed..... 2-4-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-6)

01565

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll

City or town Sykesville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 10 mon. 25 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 1 yr. 10 mon. 25 days

3. (a) FULL NAME

Benjamin F. Hobbs

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Separated

6. (b) Name of husband or wife Cecellia Schrufer Hobbs

1903

7. Birth date of deceased (mo., day, yr.) Jan. 11, 1898

8. AGE: Years 47 Months 1 Days 8 It less than one day hrs. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation Lithographer

11. Industry or business

MOTHER FATHER
12. Name James B. Hobbs
13. Birthplace Maryland

MOTHER
14. Maiden name Elizabeth Veritll
15. Birthplace Maryland

16. Informant Mrs. Nellie Piercy, sister

Address 1441 N. Bond St., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 22, 1945
(month) (day) (year)

Cemetery or crematory Baltimore Cemetery

Location Balto. Md.

18. Funeral director William Cook, Inc.

Address 1217 1/2 Paul St. Balto. Md.

19. (Date rec'd by registrar) Feb. 20 1945 C. Harry War

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore City

City or town Baltimore, Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

215-22-9437

MEDICAL CERTIFICATION

20. DATE OF DEATH February 19 1945 at 12:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 24 1943 to Feb. 19 1945

and that I last saw h. i. a. alive on Feb. 19 1945

Immediate cause of death Pulmonary tuberculosis

DURATION 1 year

Due to

Due to

Other conditions

Psychosis & Huntington's chorea

(Include pregnancy within 6 months of death) 2 yrs.

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

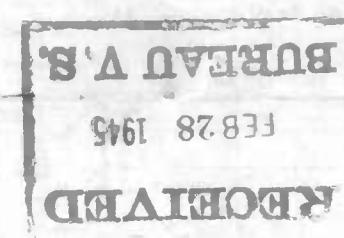
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edward Z. Kerman

M. D. or other

Address Sykesville, Md. Date signed 2-19-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01566

74

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH: Carroll
County Henryton

City or town..... (If outside city or town limits, write RURAL and give nearest town)
3 months, 11 days

How long in above place of death?.....
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.

How long in hospital or institution?.....

3. (a) FULL NAME

SHIRLEY HOWARD

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	col.	single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) July 11, 1939
..... (c) If alive, give age years

8. AGE: Years	Months	Days	If less than one day
5	7	17 hrs. min.

9. Birthplace..... Baltimore, Maryland
(Town, county, and state)

10. Usual occupation..... None

11. Industry or business

12. Name..... Charles Elliott

13. Birthplace..... Unknown

14. Maiden name..... Pearl Howard

15. Birthplace..... Baltimore, Md.

16. Informant..... Reuben Hoffman, M.D.

Address..... Henryton, Md.

17. Burial..... Date thereof..... 3/3/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Mt. Calvary

Location..... A.A.C. m.d.

18. Funeral director..... Sarah L. Broewson

Address..... 108W Montgomery Street

19. Feb. 28, 1945..... Deputy Local Registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No..... 733 Stirling St. (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 28, 1945, 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 17, 1944, to Feb. 28, 1945, and that I last saw her alive on February 28, 1945.

Immediate cause of death..... Tuberculous Meningitis

DURATION

2-26-45

Due to..... Pulmonary Tuberculosis

7-16-44

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... Reuben Hoffman, M.D.

M. D. or other

Address..... Henryton, Md. Date signed..... 2-28-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-1

01567

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County

CARROLL

City or town

WESTMINSTER

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

7 YEARS

Hospital, institution, or street address where death occurred:

M. P. CHURCH HOME FOR AGED

How long in hospital or institution?

7 YEARS

3. (a) FULL NAME

ANDREW M. HUNTER

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

MALE

WHITE

MARRIED

6.(b) Name of husband or wife

EMMA C. BREGEL

7. Birth date of deceased (mo., day, yr.)

MARCH 17, 1858

6.(c) If alive, give age

87

years

8. AGE:

Years

Months

Days

If less than one day

91

10

16

.hrs.

.min.

9. Birthplace

BALTIMORE, MD

(Town, county, and state)

10. Usual occupation

RETIRED

11. Industry or business

FATHER

12. Name

ANDREW HUNTER

13. Birthplace

MARYLAND

MOTHER

14. Maiden name

ELIZABETH WEST

15. Birthplace

MARYLAND

16. Informant

MRS. D. S. GEHR

Address

WESTMINSTER, MD.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

2/5/45
(month) (day) (year)

Cemetery or crematory

BALTIMORE CEMETERY

Location

BALTIMORE, MD.

18. Funeral director

J. FRANCIS REESE

Address

WESTMINSTER, MD.

19. (Date rec'd by registrar)

1945-2/5/45

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

MARYLAND

County

CARROLL

City or town

WESTMINSTER

(If outside city or town limits, write RURAL and give nearest town)

Street No.

E. MAIN ST.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH

FEBRUARY 2, 1945 at 6:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1945-2/2/45 to 1945-2/2/45

and that I last saw h. in a state of

Immediate cause of death

coronary

occlusion

of myocarditis

arteriosclerosis

DURATION

7 hrs

many years

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

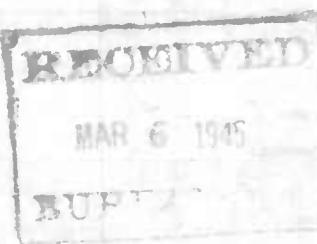
Means of injury

Injured at work?

23. SIGNATURE

L. Woodward M. D. or other

Address 7735turner Date signed 2/5/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

01568

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
Carroll County
City or town. Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 months, 28 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State. Maryland County
City or town. Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 902 Park Avenue
(If rural, give LOCATION) ✓

2.(a) If veteran, name war

3. (a) FULL NAME
GRACE IRBY
3. (b) Social Security Number
Lost

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced
Female Colored Married

6.(b) Name of husband or wife William Irby

7. Birth date of deceased (mo., day, yr.) April 19, 1917
6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day
27 10 8 hrs. min.

9. Birthplace Philadelphia, Pa.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business at home
FATHER 12. Name Henry Lambert

MOTHER 13. Birthplace Blackstone, Va.

14. Maiden name Christine Pegan
15. Birthplace Blackston, Va.

16. Informant Reuben Hoffman, M. D.
Address Henryton, Md.

17. Removal Date thereof 3/3/45
(Burial, cremation, or removal. Which?) Williams Cemetery
(Month) (day) (year)

Cemetery or crematory Mt. Auburn
Location Battle ready Crewe, Virginia

18. Funeral director Chas. G. Codner
Address 512 N. Carrollton Ave.

19. 2/27 Date rec'd by registrar 19 45 Albertha Smith
Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 27, 1945 at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 30, 1944, to Feb., 27, 1945
and that I last saw her alive on February 27, 1945.

Immediate cause of death Pulmonary Tuberculosis
DURATION Sept. 1943

Due to:

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

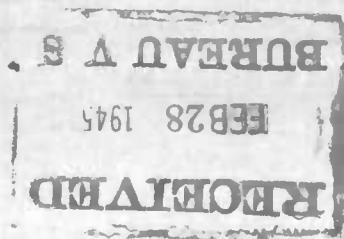
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman, M.D.

M. D. or other

Address Henryton, Md. Date signed 2/27/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-2

CERTIFICATE OF DEATH

Reg. Dist. No. 74

01569

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 4 mo's. 3 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1113 W. Lexington Street
(If rural, give LOCATION)

3. (a) FULL NAME
JAMES EDDIE JACKSON

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	colored	married

6. (b) Name of husband or wife..... Fannie Jackson

7. Birth date of deceased (mo., day, yr.) April 10, 1904
B. (c) If alive, give age. 31 years

8. AGE: Years	Months	Days	If less than one day
40	9	28	hrs. min.

9. Birthplace..... Calvert County, Md.
(Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business..... Unknown

12. Name..... Addie Chase

13. Birthplace..... Maryland

14. Maiden name..... Alexander Jackson
--

15. Birthplace..... Maryland

16. Informant..... Reuben Hoffman, M. D.

Address..... Henryton, Md.

17. Burial..... Burial Date thereof 2/10/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Mt Auburn

Location..... Balt. Md.

18. Funeral director..... Charles H. Cooper

Address..... 512 N. Carrollton Ave.

19. 2/7 1945 Albert R. Swanson
(Date rec'd by registrar) Deputy Local Registrar

3. (b) Social Security Number
216-05-1539

MEDICAL CERTIFICATION

20. DATE OF DEATH February 7, 1945 at 12.30 A

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 4, 1943 to Feb. 7, 1945 and that I last saw him alive on February 7, 1945.

Immediate cause of death..... Pulmonary Tuberculosis

DURATION
April 1943

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

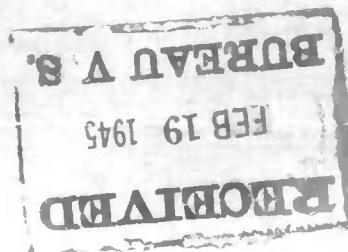
Means of injury.....

Injured at work?

23. SIGNATURE..... Reuben Hoffman, M.D.

M. D. or other

Date signed 2/7/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

01570

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County CARROLLCity or town WESTMINSTER

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 YEARS

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

WILLIAM EDGAR JACKSON

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MALE

WHITE

MARRIED

6. (b) Name of husband or wife

SARAH MAXWELL

6. (c) If alive, give age

77

years

7. Birth date of deceased (mo., day, yr.)

NOVEMBER 3, 1868

8. AGE:

Years

Months

Days

If less than one day

76

3

7

hrs.

min.

9. Birthplace

CORNWALL, N.Y.

(Town, county, and state)

10. Usual occupation

RETIRED

11. Industry or business

JAMES JACKSON

12. Name

JAMES JACKSON

13. Birthplace

NEW YORK

14. Maiden name

MARY ADAMS

15. Birthplace

NEW YORK

16. Informant

MRS. F. G. HOLLOWAY

Address

WESTMINSTER, MD.

17. BURIAL

(Burial, cremation, or removal. Which?)

Date thereof 2/13/45

(month) (day) (year)

Cemetery or crematory

WESTMINSTER CEM.

Location

WESTMINSTER, MD.

18. Funeral director

FRANCIS REESE

Address

WESTMINSTER, MD.

19. (Date rec'd by registrar)

2/12/45

19

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLANDCounty CARROLLCity or town WESTMINSTER

(If outside city or town limits, write RURAL and give nearest town)

Street No. WESTERN MARYLAND COLLEGE

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 10

1945 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Jan. 24 1945 to Feb. 10 1945 and that I last saw him alive on Feb. 10 1945

Immediate cause of death

Bronchopneumonia

DURATION

3 days

Due to interstitialis Cardi-
vascular disease

years

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

None

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

James T. Sharpe

M. D. or other

Date signed

2/11/45

RECEIVED

MAR 6 1945

BUREAU



PLEASE WRITE PLAINLY, WITH ~~INK~~ FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

CERTIFICATE OF DEATH

01571

82

Reg. Dlat. No.

1. PLACE OF DEATH:

County Carroll
 City or town Ridgerville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Elsie Kelly

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Percy Kelly

7. Birth date of deceased (mo., day, yr.)

Dec 4 18816. (c) If alive, give age 64 years

8. AGE:

Years <u>63</u>	Months <u>2</u>	Days <u>15</u>	If less than one day hrs. min.
-----------------	-----------------	----------------	---

9. Birthplace

MD
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

S. B. Norwood

FATHER

12. Name S. B. Norwood13. Birthplace MD

MOTHER

14. Maiden name Laura Wood15. Birthplace MD

16. Informant

Percy KellyAddress Mount airy MD17. Burial Burial Date thereof Feb 26 - 45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory New Market CemeteryLocation New Market MD18. Funeral director H. E. TolsonAddress New Market MD19. Date rec'd by registrar Feb 19 1945 Mrs D Snyder

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County CarrollCity or town Ridgerville (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 19 1945 at 8:30 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1943 to Feb 19 1945 and that I last saw her alive on Feb 19 1945

Immediate cause of death

Cerebral Hemorrhage DURATION 3 days

Due to

Arterio Sclerosis

(Cerebral)

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

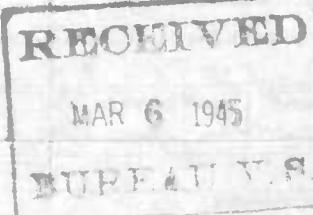
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

O. M. Kelly, Poole M. D. or otherAddress MT airy MD Date signed 2/19/45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

01572

Reg. Dist. No. 70

CERTIFICATE OF DEATH

✓ PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1 MARGIN RESERVED FOR BINDING

1

VS A15

1. PLACE OF DEATH:
County Baltimore

City or town Jamestown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME
Mrs Mary Jane Kiser

4. Sex F 5. Color or race W (a) Single, married, widowed, or divorced
widow

6. (b) Name of husband or wife John Kiser

7. Birth date of deceased (mo., day, yr.) April 10, 1869 8. (c) If alive, give age years

8. AGE: Years 75 Months 10 Days W If less than one day hrs. min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Housework

11. Industry or business Wm. Rose

MOTHER FATHER 12. Name Isabella Spangler

13. Birthplace Md

14. Maiden name Isabella Spangler

15. Birthplace Pa

16. Informant Mrs Grace Heding

Address Dundalk Md

17. Burial Burial Date thereof Feb 28, 1945
(Burial, cremation, or removal? Which?) (month) (day) (year)

Cemetery or crematory Luthian

Location Jamestown Md

18. Funeral director John Fussell

Address Jamestown Md

19. Date rec'd by registrar Feb 27 1945

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State County

City or town Jamestown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 107 Fussell
(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (b) Social Security Number None

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25th 1945 at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 24th 1945 to Feb. 25th 1945 and that I last saw her alive on Feb. 25th 1945

Immediate cause of death Paroxysmal
hemorrhage 3 duration 2 days

Due to Arteric Sclerosis 5 yrs

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

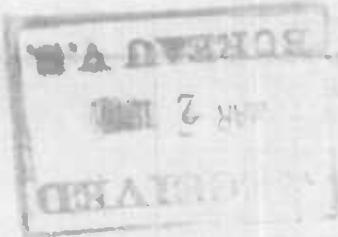
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. M. Berner M.D. M. D. or other

Address Jamestown Md Date signed 2/26/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 16

CERTIFICATE OF DEATH

Reg. Dist. No. 76

01574

1. PLACE OF DEATH:

County

Carroll

City or town

Finksburg Md RD #1

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

2 day

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Nellie Marie Knight

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

8. (b) Name of husband or wife

6. (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

Feb 3, 1945

8. AGE:

Years Months Days If less than one day
0 0 1 hrs. min.

9. Birthplace

Lawndale - Finksburg Md -
(Town, county, and state)

10. Usual occupation

Infant

11. Industry or business

Infant

12. Name

Samuel Bennett Knight

13. Birthplace

Miami Florida

14. Maiden name

Addie Mae Sabine

15. Birthplace

Lafayette Co. Ga

16. Informant

Addie Mae Sabine

Address

Finksburg Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 2-5-45

(month) (day) (year)

Cemetery or crematory

Emory church

Location

Carroll Co. Md

18. Funeral director

Edwin C. Tipton

Address

Stampestdale Md

19. (Date rec'd by registrar)

19-41-57

Signature of Registrar

Maurice C. Partinfield

M.D. or other

Address

Stampestdale Md

Date signed 2-4-45

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Street No.

Maryland County Carroll

(If outside city or town limits, write RURAL and give nearest town)

Lawndale

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 4

19 1945 at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 3 1945 to Feb 4 1945

and that I last saw her alive on Feb 3, 1945

Immediate cause of death

Hemorrhage Disease
of Newborn

DURATION

1 1/2 day

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Maurice C. Partinfield
M.D. or other

Signature of physician or other medical officer

Address

Stampestdale Md

Date signed 2-4-45

RECEIVED

MAR 6 1945

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

01575

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

Carroll

County

Henryton, Md.

City or town

(If outside city or town limits, write RURAL and give nearest town)

12 days

How long in above place of death?

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland

How long in hospital or institution?

3. (a) FULL NAME

ELIZABETH LEGGETT

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

female

colored

married

Vernon Leggett

6.(b) Name of husband or wife

6.(c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.)

Jan. 20, 1918

8. AGE:

Years

Months

Days

If less than one day

27

1

1

.....hrs.

.....min.

9. Birthplace

Aiken, S.C.

(Town, county, and state)

10. Usual occupation

Waitress

11. Industry or business

Thomas Williams

12. Name

MOTHER FATHER

Aiken, S.C.

13. Birthplace

14. Maiden name

Maggie Brown

15. Birthplace

Aiken, S.C.

16. Informant

Reuben Hoffman, M.D.

Address

Henryton, Maryland

17. Burial

(Burial, cremation, or removal. Whicht)

Date thereof 2/21/45
(month) (day) (year)

Cemetery or crematory

Arboretum Mem Park

Location

Baltimore, Md.

18. Funeral director

M. George Hall

Address

1631 Druid Hill Ave

19. Date rec'd by registrar

Feb. 21, 1945

(Date rec'd by registrar)

Albert R. Savannah

Deputy Local Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Baltimore

(If outside city or town limits, write RURAL and give nearest town)

578 Oxford Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

213-18-6475

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH

Feb. 21,

1945

8:55 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Feb. 9, 1945, to Feb. 21, 1945.

and that I last saw her alive on February 21, 1945.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

Oct.

1944

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

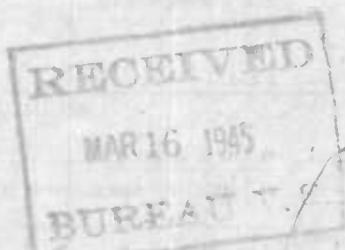
Reuben Hoffman, M.D.

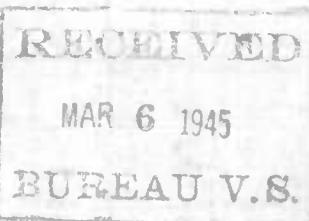
M. D. or other

Address Henryton, Md.

Date signed 2-21-45







1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 16

CERTIFICATE OF DEATH

01578

70

Reg. Dist. No.

1. PLACE OF DEATH:

County CarrollCity or town Taneytown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Margaret E. Megee

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

FemaleWhiteSingle

8. (b) Name of husband or wife.....

6. (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 6, 1888

8. AGE:

Years

Months

Days

It less than one day

56

4

10

hrs.

min.

9. Birthplace.....

New Jersey
(Town, county, and state)

10. Usual occupation.....

Housework

11. Industry or business

12. Name John W. Megee13. Birthplace New Jersey14. Maiden name Ella M. Crass15. Birthplace Maryland16. Informant Mrs. Pina J. MullerAddress Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?)

Date thereof Feb. 17, 1946
(month) (day) (year)Cemetery or crematory New Cathedral CemeteryLocation Baltimore, Md (4300 Old Frederick Rd)18. Funeral director C. O. Guss & SonAddress Taneytown, Md.19. Heb. 16 1945 Ethel M. Mahring

(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty BaltimoreCity or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 217 Allendale Street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

212-01-9852

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 15, 1946 at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 12, 1945 to Feb. 15, 1946 1945and that I last saw her alive on Feb. 15, 1946 1945Immediate cause of death Lowering Embolus DURATION3 daysDue to Diabetes Mellitus 6 am

with abscess foot

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

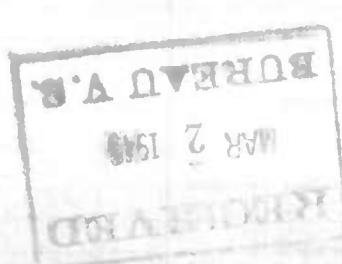
Injured at work?

23. SIGNATURE

C. M. Bernier M.D.

M. D. or other

Address Taneytown, Md. Date signed Feb. 16, 1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

01579

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 3 mo's., 25 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Harford
City or town Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

KING SOLOMON MILLER

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
<u>Male</u>	<u>Colored</u>	<u>Married</u>

6.(b) Name of husband or wife Jessie B. Miller

7. Birth date of deceased (mo., day, yr.) October 12, 1902
8. (c) If alive, give age _____ years

8. AGE: Years	Months	Days	If less than one day
<u>42</u>	<u>4</u>	<u>11</u>	hrs. _____ min. _____

9. Birthplace Aberdeen, Md.
(Town, county, and state)

10. Usual occupation Railroad Trackman

11. Industry or business Unknown

FATHER 12. Name Friday Miller

MOTHER 13. Birthplace South Carolina

14. Maiden name Christie Brown

15. Birthplace South Carolina

16. Informant Heuben Hoffman, M. D.

Address Henryton, Md.

17. Burial Burial
(Burial, cremation, or removal. Which?) Date thereof Feb. 25, 45
(month) (day) (year)

Cemetery or crematory Aberdeen, Md.

Location Aberdeen, Md.

18. Funeral director Elmer E. Bullock

Address 556 Lewis St. Havre de Grace

19. 2/23 19. 45 Alfred R. S. 11
(Date rec'd by registrar) Deputy Local 11
Registrar

3. (b) Social Security Number

705-09-7569

MEDICAL CERTIFICATION

20. DATE OF DEATH February 23, 1945 at 8.00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 29, 1943, to Feb. 23, 1945, and that I last saw him alive on February 23, 1945.

Immediate cause of death Pulmonary Tuberculosis DURATION Aug. 5, 1943

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings or operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Heuben Hoffman, M. D. M. D. or other _____

Address Henryton, Md. Date signed 2/23/45

RECOLL

MAR 6 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

01589

Reg. Dist. No. 82

1. PLACE OF DEATH: Carroll
 County: Ridgeville

City or town: (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution? _____

3. (a) FULL NAME

Charles Robert Moxley

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M White Married

6. (b) Name of husband or wife

Madeleine Moxley

7. Birth date of deceased (mo., day, yr.)

May 31 1894 51 years

8. AGE:

Years	Months	Days	It less than one day
<u>60</u>	<u>8</u>	<u>16</u>	hrs. min.

9. Birthplace

Frederick Co
(Town, county, and state)

10. Usual occupation

Tabor

11. Industry or business

Zekiel MoxleyMontgomeryHattie MoxleyMontgomery CoMadeleine MoxleyCarrollFeb. 18, 1945Burial Feb. 18, 1945
(Burial, cremation, or removal. Which?)Montgomery ChapelNear Damascus Montgomery Co.H. M. SnyderMt. Airy Md.Feb. 17, 1945 John D. Snyder

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)State: Md. County: CarrollCity or town: Ridgeville Md. (If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give location)

2.(a) If veteran, name war: World War I

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

February 16 1945 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19..... to..... 19.....

and that I last saw h. alive on 19..... 19.....

Immediate cause of death

Coronary occlusion

Due to

arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

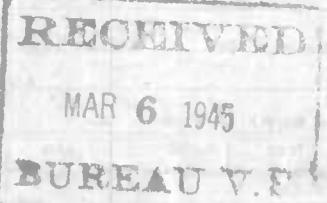
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James P. Stark Deputy State Coroner
M. D. or other
Geo. W. Weller Feb. 16, 1945
Address: _____ Date signed: _____



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01581

CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH

County

City or town

Capitol
Hydesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs 11 mos 16 da

Hospital, institution or street address where death occurred

Springfield State Hospital

How long in hospital or institution? 4 yrs 11 mos 16 da

3. (a) FULL NAME

4. Sex

J W Widowed

5. Color or race

6. (a) Single, married, widowed, or divorced

B. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

July 18 62

8. AGE:

Years	Months	Days	If less than one day
82			hrs. min.

9. Birthplace

10. Usual occupation

11. Industry

business

Maryland
housewife

12. Name

Fredrick Taymey

13. Birthplace

14. Maiden name

Maryland

15. Birthplace

Capitol Hydesville

16. Address

613 E 33d St Baltimore

17. Burial

Burial, cremation, or removal. Which? Cemetery or crematory

Location

18. Funeral director

Address

Wm Cook Inc.

19. Date rec'd by registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Street No.

(If outside city or town limits, write RURAL and give nearest town)

(If rural, give LOCATION)

County

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 27 1945 at 8 a.m.

Mar. 1st 1945 Oct. 27 1945

and that I last saw her alive on Oct. 27th 1945

Immediate cause of death

Chronic Endocarditis 4 yrs

Due to

Arterio Sclerotic 8

Other conditions

Hyperension 8

(Include pregnancy within 8 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address Date signed

Hydesville 10/27/45



1
PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01582

70

Reg. Dist. No.

1. PLACE OF DEATH: Carroll
 County: Taneytown
 City or town: Taneytown (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 26 yrs
 Hospital, Institution, or street address where death occurred: _____
 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State: MD County: Carroll
 City or town: Taneytown (If outside city or town limits, write RURAL and give nearest town)
 Street No.: _____ (If rural, give LOCATION)

3. (a) FULL NAME: Albert J. Ohler
 4. Sex: M 5. Color or race: W 6. (a) Single, married, widowed, or divorced: married
 6. (b) Name of husband or wife: Carrie R. Ohler
 7. Birth date of deceased (mo., day, yr.): Oct 25 1867 8. (c) If alive, give age: 79 years
 8. AGE: Years: 77 Months: 4 Days: 3 If less than one day: _____ hrs: _____ min: _____
 9. Birthplace: MD (Town, county, and state)
 10. Usual occupation: Carpenter
 11. Industry or business: Construction
 MOTHER FATHER
 12. Name: Andrew J. Ohler
 13. Birthplace: MD
 14. Maiden name: Mary E. Fleagle
 15. Birthplace: MD
 16. Informant: Mrs. A. J. Ohler
 Address: Taneytown MD
 17. Burial: Burial Date thereof: Mar 3, 1945 (Burial, cremation, or removal, when)
 Cemetery or crematory: Luth. Cem.
 Location: Taneytown MD
 18. Funeral director: Left Coast Son
 Address: Taneytown MD
 19. March 1945 - Ethel M. Mehling
 (Date rec'd by registrar)

2. (a) If veteran, name war: _____

3. (b) Social Security Number: none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 28, 1945 at 11:57 AM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1945 to Mar 28, 1945 and that I last saw him alive on Mar 28, 1945

Immediate cause of death: Angina Pectoris
 Due to: arterio sclerosis
 Due to: _____
 Duration: 9 days
 21. Date of op.: 2/27/45

Other conditions: _____
 (Include pregnancy within 8 months of death)

Major findings of operations: _____ Date of op.: _____

Autopsy results: _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide: _____ Date of: _____

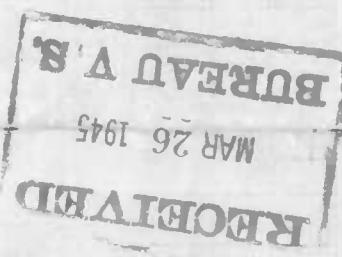
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE: G. M. Bessner MD M. D. or other: _____

Address: Taneytown MD Date signed: 3/2/45



M

Evidence for item 10 & 11-
phone call from undertaker MARYLAND STATE DEPARTMENT OF HEALTH
2/15/45 dm 2411 N. Charles St., Baltimore 77

01583

74

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County..... Carroll
City or town..... rural near Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 months, 9 days

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 8 months, 9 days

3. (a) FULL NAME

Louis Krebs Owen

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife..... Sarah F. Owen

7. Birth date of deceased (mo., day, yr.) March 17, 1889

8. AGE: Years	Months	Days	If less than one day
55	10	27	hrs. min.

8. Birthplace..... Baltimore City, Maryland
(Town, county, and state)

10. Usual occupation..... Bookkeeper & Manager

11. Industry or business..... Self - Chesapeake Manufacturing

12. Name..... George F. Owen

13. Birthplace..... Maryland

14. Maiden name..... Mary Smith

15. Birthplace..... Maryland

16. Informant..... Springfield State Hosp. records

Address..... Sykesville, Maryland

17. Burial..... Date thereof 2/17/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Druid Ridge Cem.

Location..... Rikesville, Md.

18. Funeral director..... WM. J. TICKNER & SONS

Address..... Balto., Md.

19. 2-16-45
(Date rec'd by registrar)G. W. Herkis
pe 620

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State..... Maryland County..... BaltimoreCity or town..... Towson, 4
(If outside city or town limits, write RURAL and give nearest town)

Street No..... 617 York Road

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

212-03-1469

MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 14 1945 10:45a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 8 1944, to Feb. 14 1945, and that I last saw him alive on February 14 1945.

Immediate cause of death..... Arteriosclerosis
DURATION..... 7 years

Due to.....

Due to.....

Ca.....

Other conditions..... Psychosis with cerebral arteriosclerosis
(Include pregnancy within 8 months of death) 2 years

Major findings of operations..... Date of op.....

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury..... Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE..... Robert Bertrand May, M.D.
Springfield State Hospital M.D. or other
Address..... Sykesville, Maryland Date signed 2-14-45

Rec'd U.S.
2/15/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

01584

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 27

CERTIFICATE OF DEATH

Reg. Dist. No. 7H

1. PLACE OF DEATH:
County Carroll

City or town near Sykesville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs., 11 mos., 16 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 3 yrs., 11 mos., 16 days

3. (a) FULL NAME
Albert Pedro

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Widowed</u>
--------------------	-------------------------------	---

6. (b) Name of husband or wife Bessie Tawkersly

7. Birth date of deceased (mo., day, yr.) Exact date unknown.

8. AGE: Years <u>68 (?)</u>	Months <u>?</u>	Days <u>?</u>	If less than one day <u>hrs. min.</u>
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9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation Odd jobs.

11. Industry or business

MOTHER FATHER 12. Name Albert J. Pedro

13. Birthplace Portugal

14. Maiden name Frances Edkins

15. Birthplace Surrey, England

16. Informant Springfield Hospital Record

Address Sykesville, Maryland

17. Burial Burial Date thereof Feb. 26, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greenmount Cemetery

Location Baltimore, Md.

18. Funeral director John J. Mitchell & Son

Address 1960 Caton Place

19. Feb. 22, 1945 C. Harry Baer
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 502 Hollen Road
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22, 1945 1:15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 31, 1944 to February 22, 1945

and that I last saw him alive on February 22, 1945

Immediate cause of death

Cerebral arteriosclerosis prior to 3-6-41

Due to

Due to

Other conditions Psychosis with cerebral arteriosclerosis prior to 3-6-41
(Include pregnancy within 3 months of death)

Major findings or operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

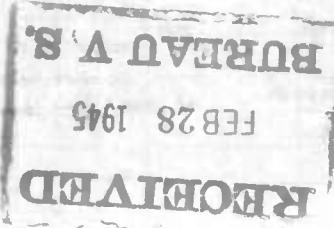
Means of injury

Injured at work?

23. SIGNATURE Harry J. Baer, M.D.

M. D. or other

Address Sykesville, Md. Date signed 2-22-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

01585

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH: *Carroll*
 County: *Carroll*
 City or town: *Wheaton - Rural*
 (If outside city or town limits, write RURAL and give nearest town) *One year*
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 Now long in hospital or institution? *None*

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State: *Maryland* County: *Carroll*
 City or town: *Wheaton - Rural*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.: *None* (If rural, give LOCATION)

2.(a) If veteran, name war...

3. (a) FULL NAME

Laura A.

4. Sex: *Female* 5. Color or race: *White* 6.(a) Single, married, widowed, or divorced: *Married*
 B. (b) Name of husband or wife: *George Washington Rill*

7. Birth date of deceased (mo., day, yr.) *Nov 7-1864* 8. (c) If alive, give age: *84* years

8. AGE: Years *80* Months *3* Days *14* If less than one day: *hrs.* *min.*

9. Birthplace: *Baltimore Co. Maryland*
 (Town, county, and state)

10. Usual occupation: *Housework -*

11. Industry or business

MOTHER FATHER 12. Name: *William Barber*

13. Birthplace: *Maryland -*

14. Maiden name: *Hannah Rock*

15. Birthplace: *Maryland -*

16. Informant: *George W. Rill*

Address: *Westminster, Maryland R.R. 3.*

17. Burial: *Burial* ✓ Date thereof: *2-18-45*
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: *Wesley*

Location: *Carroll County*

18. Funeral director: *John C. Dickey*

Address: *Hampstead Md*

19. *Feb. 17* 1845-910 H. P. S. Deemer
 (Date rec'd by registrar)

3. (b) Social Security Number

Rill

MEDICAL CERTIFICATION

20. DATE OF DEATH: *February 15* 1945 21. 1945 1945

I CERTIFY that death occurred on the date above stated; that I attended deceased from *August 21* 1945 to *February 15* 1945 and that I last saw her alive on *February 14* 1945

Immediate cause of death: *Acute Coronary Thrombosis* DURATION *2 hrs.*

Due to: *Ch. Nephritis -* 6 yrs.

Due to: *Ch. Atherosclerosis* 10 years.

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

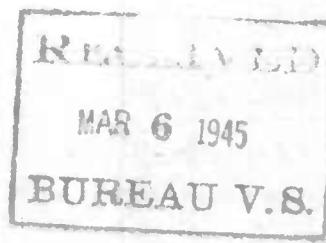
Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: *Strether Rill (M.D.)* M. D. or otherAddress: *Westminster, Maryland* Date signed: *Feb. 17, 1945.*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *18-62*

CERTIFICATE OF DEATH

01586
Reg. Diat. No.

74

1. PLACE OF DEATH:

County *Carroll*City or town *Sykesville*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *27 years*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

*Ida Loving Rucker*4. Sex *W*5. Color or race *W*6. (a) Single, married, widowed, or divorced *Widowed*6. (b) Name of husband or wife *Wm B. Rucker*

7. Birth date of deceased (mo., day, yr.)

March 4, 1856

8. (c) If alive, give age years

8. AGE:

Years *88*Months *11*Days *24*

If less than one day hrs. min.

8. Birthplace *Orchard, Va.*

(Town, county, and state)

10. Usual occupation *Housewife*11. Industry or business *None*

MOTHER FATHER

12. Name *Ida Lee Rucker*13. Birthplace *Va.*14. Maiden name *Sallie Sandidge*15. Birthplace *Va.*16. Informant *Mr. Samuel Rucker*

Address

Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?)

Date thereof *Mar. 1, 1945*
(month) (day) (year)Cemetery or crematory *Oak Grove Cemetery*Location *Glenswood Howard Co. Md.*18. Funeral director *C. J. Gray Jr.*

Address

*Sykesville, Md.*19. Date rec'd by registrar *Mar. 1 1945**C. Gray Jr.*

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.*County *Carroll*City or town *Sykesville*

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name w/.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

February 26 1945 at 10:35 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

February 23 1945 to February 26 1945

and that I last saw h..... alive on 19.....

Immediate cause of death.....

*cardiac arrest whch
following an accidental fall*

DURATION

Due to.....

*Fracture of radius & ulnar*Due to..... *accidental fall*Other conditions *Senility*

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *accidental* Date of *2/23/45*Where did injury occur? *Sykesville Carroll Md.*
(city or town) (County) (State)Injured at home, farm, industry, public place (where?) *Home*Means of injury *fell down stairs* Injured at work? *No*23. SIGNATURE *Dr. Lawrence M.D.*

M. D. or other

Address *Sykesville, Md.*Date signed *Feb. 27 1945*

RECEIVED
MAR 6 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3

01587

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County CarrollCity or town Sykesville, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, Institute, or street address where death occurred:

Springfield State HospitalHow long in hospital or institution? 4 days

3. (a) FULL NAME

John Sheldon

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Ida Weise

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

December 25 - 1861

8. AGE:

Years
83Months
1Days
22If less than one day
hrs. min.

9. Birthplace

Baltimore, Md.
(Town, county, and state)

10. Usual occupation

Huckster

11. Industry or business

MOTHER FATHER

12. Name John Sheldon

13. Birthplace

Maryland

14. Maiden name

Barnes

15. Birthplace

Maryland

16. Informant

Hospital records

Address

Sykesville, Md.

17. Burial

(Burial, cremation, or removal) Which?

Date thereof Feb 20, 1945
(month) (day) (year)

Cemetery or crematory

London Park Cemetery

Location

Baltimore, Md.

18. Funeral director

Emmerson, Inc.

Address

412 Franklintown Rd.

19. Feb 16 1945

(Date rec'd by registrar)

C. Harry Eber

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 814 Washington Blvd

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 194521. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 12 1945 to February 16 1945 and that I last saw him alive on February 15 1945

Immediate cause of death

Chronic Myocarditis and Myocardial degeneration

Due to

Due to

Other conditions Cerebral arteriosclerosis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

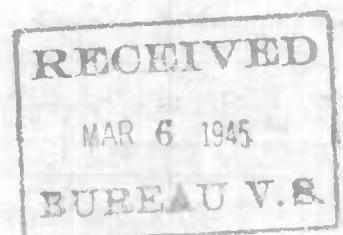
Means of injury

Injured at work?

23. SIGNATURE M. Virginia Beyer

M. D. or other

Address Sykesville, Md.Date signed Feb 16 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30-6

01588

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: Carroll
County.....
City or town..... rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yr., 4 mo., 24 days
Hospital, institution, or street address where death occurred: Springfield State Hospital
4 yr., 4 mo., 24 days
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County.....
City or town..... Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME
Charles Harold Sheppard

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced	
male	white	married	
6.(b) Name of husband or wife..... Sadie V. Mimick			
8.(c) If alive, give age..... years			
7. Birth date of deceased (mo., day, yr.) November 19, 1888			
8. AGE: Years	Months	Days	It less than one day
56	3	6	hrs. min.

9. Birthplace.....	Baltimore, Maryland (Town, county, and state)
10. Usual occupation.....	Sales clerk
11. Industry or business.....	Hardware, retail
12. Name.....	Benjamin F. Sheppard
13. Birthplace.....	Baltimore, Maryland
14. Maiden name.....	Alice Burton
15. Birthplace.....	Baltimore, Maryland
16. Informant.....	Records, Springfield State Hosp
Address.....	Sykesville, Maryland

17. Burial.....	Date thereof..... May 1, 1945 (Burial, cremation, or removal? Which?)
Cemetery or crematory.....	London Park
Location.....	Bald, Md.
18. Funeral director.....	William Cook Inc.
Address.....	1217 St. Paul St.
19. Date rec'd by registrar.....	Feb. 26 1945 (Date rec'd by registrar)
C. Harry E. Lee Registrar	

MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 25 1945 10:10 p.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 1 1943 to Feb. 25 1945 and that I last saw him alive on February 25 1945.

Immediate cause of death.....
General paralysis of the insane
DURATION..... 6 years

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE..... Robert Bertrand May, M.D.

Springfield State Hospital M. D. or other

Address..... Sykesville, Maryland Date signed..... 2-25-45

RECEIVED

MAR 6 1945

BUREAU V.S.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *2d*

01589

CERTIFICATE OF DEATH

Reg. Dist. No. *72*

1. PLACE OF DEATH:
County *Carroll*

City or town *Union Mills*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *9.3*

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME *Louis Edwin Shriner*

4. Sex *M* 5. Color or race *W* 6. (a) Single, married, widowed, or divorced *single*

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) *Nov. 16 - 1851*

8. AGE: Years *93* Months *2* Days *15* If less than one day *hrs. min.*

9. Birthplace *Carroll Co. Md.*
(Town, county, and state)

10. Usual occupation *none*

11. Industry or business

12. Name *Louis Edwin Shriner*

13. Birthplace *Md.*

14. Maiden name *Katherine Wirt*

15. Birthplace *Hanover, Pa.*

16. Informant *Mrs. Elizabeth Kempf*

Address *Union Mills, Carroll Co. Md.*

17. Burial *Burial* Date thereof *Feb. 5 - 1945*
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Mt. Olivet*

Location *Hanover, Pa.*

18. Funeral director *Frederick Bucher*

Address *Hanover, Pa.*

19. Date *Feb. 3rd* 1945
(Date rec'd by registrar)

Calvin Baumer
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State *Maryland* County *Carroll*

City or town *Union Mills*
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number *none*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Feby 2nd* 1945 at *12 noon*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 21 - 1945 to *Feby 2 - 1945*

and that I last saw him *alive* on *Feby 2 - 1945*

Immediate cause of death *acute Delirious*
of heart

Due to *chronic myo. Carditis* DURATION *20 min*

Duo to *arterio Sclerosis* *5 yrs*

Other conditions *.....*

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

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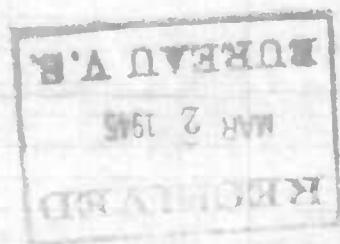
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RECEIVED FEDERAL BUREAU OF INVESTIGATION

RECEIVED

MAR 16 1945

FEDERAL BUREAU OF INVESTIGATION



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 460

CERTIFICATE OF DEATH

01591

Reg. Dist. No. 60

1. PLACE OF DEATH:

County.....

City or town.....

Carroll

New Windsor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred: Legg

How long in hospital or institution?.....

3. (a) FULL NAME

Luther Stultz

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife

Ada Stultz

7. Birth date of deceased (mo., day, yr.)

Feb 25 - 1888

6. (c) If alive, give age

years

8. AGE:

Years Months Days If less than one day

26 11 25 hrs. min.

9. Birthplace.....

Carroll County, Md

(Town, county, and state)

10. Usual occupation.....

Farmer

11. Industry or business

George Stultz

Maryland

14. Maiden name.....

Mary Bloom

15. Birthplace.....

Maryland

16. Informant.....

Mrs. Ada Stultz

Address.....

New Windsor, Md.

17. Burial.....

Date thereof: Feb 22-1945

(Burial, cremation, or removal. Which?)

Date thereof: (month) (day) (year)

Cemetery or crematory.....

Winters Cemetery

Location.....

Union Bridge Road

18. Funeral director.....

J. N. Legg

Union Bridge New Windsor Md

19. Date rec'd by registrar.....

7th 22 1945

Registrar.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland Carroll

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

New Windsor

Street No.....

(If rural, give LOCATION)

Rural

3. (a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 19 1945 at 11³⁰ AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

June 6 1944 to Feb 19 1945

and that I last saw him alive on Feb 19 1945

Immediate cause of death.....

Carcinoma of stomach

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE

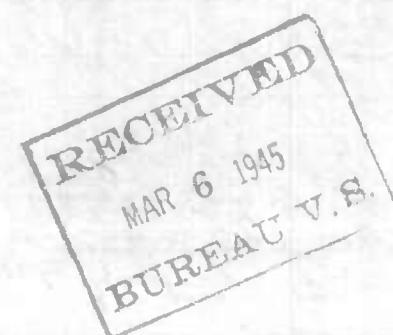
J. N. Legg

M. D. or other

Address.....

Union Bridge

Date signed 2/20/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 87-2

01592

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: Carroll.

County

City or town near Sykesville, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 yrs., 2 mos., 18 days.

Hospital, institution, or street address where death occurred:

Springfield State Hospital.

How long in hospital or institution? 14 yrs., 2 mos., 18 days.

3. (a) FULL NAME

Milton Thompson.

3. (b) Social Security Number

#

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male. White. Divorced.

6. (b) Name of husband or wife.

7. Birth date of deceased (mo., day, yr.) November 6, 1900.

6. (c) If alive, give age years

8. AGE: Years 44. Months 3. Days 16. If less than one day hrs. min.

9. Birthplace Montgomery County, Md.

(Town, county, and state)

10. Usual occupation Laborer.

11. Industry or business Farm.

12. Name William Thompson.

13. Birthplace Maryland.

14. Maiden name Gertrude Price.

15. Birthplace Maryland.

16. Informant Springfield Hospital Record.

Address Sykesville, Md.

17. Burial Date thereof Feb. 25 - 45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hyattstown Cemetery

Location Hyattstown, Maryland

18. Funeral director E. C. Watson

Address Gaithersburg, Md.

19. Feb. 23, 1945 C. Harry Baer

(Date rec'd by registrar) (Signature) (Registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Boyds.

(If outside city or town limits, write RURAL and give nearest town)

Street No. # unknown.

(If rural, give LOCATION)

2. (a) If veteran, name war.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22, 1945 21. 9 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 1936, to Feb. 22, 1945, and that I last saw him alive on February 22, 1945.

Immediate cause of death

Post-Encephalitis - prior to 12-4-30. DURATION

Due to

Due to

Psychosis with Organic Brain

Other conditions and nervous disease -

Post-Encephalitis - prior to 12-4-30. (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Harry J. Baer, M.D.

M. D. or other

Address Sykesville, Md. Date signed 2-22-45

RECEIVED
MAR 6 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

01593

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 years, 5 months, 9 days

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 16 years, 5 months, 9 days

3. (a) FULL NAME

Jennie E. Wachter

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed

8. (b) Name of husband or wife

Willard Wachter

7. Birth date of deceased (mo., dy., yr.)

August 23, 1898

(B. (c) If alive, give age years)

8. AGE:

Years
46Months
5Days
14If less than one day
hrs. min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

housewife

11. Industry or business

Isaac Rice

FATHER

Name: Isaac Rice

Birthplace: Maryland

MOTHER

Name: Mary Sheakle

Birthplace: Maryland

16. Informant

Hospital record

Address

Springfield State Hospital

17. Burial

Date thereof: Feb 10, 1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Blow Cemetery

Location

Charlesville, Md.

18. Funeral director

M. R. Etchison & Sons

Address

Frederick, Md.

19. Date reg'd by registrar

Feb. 7, 1945

(Date reg'd by registrar)

C. Harry Deed

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland

County: Frederick

City or town: Harmony, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: unknown

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

February 7, 1945, at 1:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1, 1942, to February 6, 1945,

and that I last saw her alive on February 6, 1945.

Immediate cause of death:

cerebral embolism

DURATION

2 hours

Due to: hypertension heart

disease

Due to:

Other conditions: hypertension, heart

disease

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide...

Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

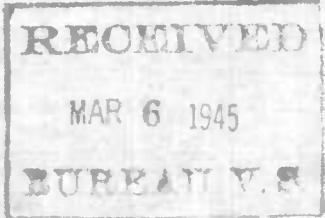
Injured at work?

23. SIGNATURE

Tenn. H. Deed, M.D.

M. D. or other

Address: Springfield State Hosp. Date signed: 2-7-45



M

MARGIN RESERVED FOR BINDING

1

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3120

01594

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County CARROLLCity or town Ridgeley (If outside city or town limits, write RURAL and give nearest town)How long in above place of death? LIFE

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

AMELIA E. WAGNER

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

WIDOW

6. (b) Name of husband or wife JOHN T. WAGNER7. Birth date of deceased (mo., day, yr.) NOVEMBER 5, 18548. AGE: Years 92 Months 3 Days 6 If less than one dayhrs. min. 9. Birthplace CARROLL COUNTY, MD.
(Town, county, and state)10. Usual occupation NONE

11. Industry or business

12. Name ALEXANDER G. SHIPLEY13. Birthplace MD.14. Maiden name MARY BROTHERS15. Birthplace MD.16. Interment ELSIE E. HOOKAddress WESTMINSTER, MD.17. Burial BURIAL Date thereof 2/12/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory ZION CEMETERYLocation CARROLL Co. MD.18. Funeral director J. FRANCIS REESEAddress WESTMINSTER, MD.19. (Date rec'd by registrar) 2/13/60 Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County CARROLLCity or town Ridgeley (If outside city or town limits, write RURAL and give nearest town)Street No. (If rural, give LOCATION)

2. (a) If veteran, name & war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 11, 1945 at 9:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 24 1945 to Feb 11 1945 and that I last saw her alive on Feb 10 1945.Immediate cause of death acute Cardiac DilatationDue to Chronic Intestinal NephritisDue to arterio sclerosis chronic

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John R. Foutz M.D. M. D. or otherAddress Westminster, MD. Date signed 2-13-45

RECEIVED

MAR 6 1945

BUREAU V.F.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

01595

CERTIFICATE OF DEATH

Reg. Dist. No. 80

1. PLACE OF DEATH: *Carroll*
County *New Windsor*

City or town *New Windsor* (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME *Charles Wilson Warner*

4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Married*

6. (b) Name of husband or wife *Mary E. Warner*

7. Birth date of deceased (mo., day, yr.) *Jan. 22 - 1865*

8. AGE: Years *80* Months *1* Days *2* It less than one day *hrs. 0* min. *0*

9. Birthplace *Frederick County Md.* (Town, county, and state)

10. Usual occupation *Labourer*

11. Industry or business

FATHER 12. Name *John W. Warner*

MOTHER 13. Birthplace *Maryland*

14. Maiden name *Susanna Fisher*

15. Birthplace *Maryland*

16. Informant *Mrs. Mary E. Warner*

Address *New Windsor, Md.*

17. Burial (Burial, cremation, or removal. Which?) *Burial* Date thereof *Feb. 28 - 1945* (month) (day) (year)

Cemetery or crematory *Pop Creek Cemetery*

Location *Elmontway Road*

18. Funeral director *W. H. Harper & Sons*

Address *Almon Bridge & New Windsor Md.*

19. Feb. 25 1945 (Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Carroll*

City or town *New Windsor* (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number *None*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Feb. 24* 1945 at *12:10 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Feb. 24* 1945 to *Feb. 24* 1945 and that I last saw him *alive* on *Feb. 24* 1945

Immediate cause of death *Cerebral hemorrhage* DURATION

Due to *Arteriosclerosis* years

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE *James T. March* M. D. or other

Address *New Windsor, Md.* Date signed *Feb. 25/45*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

01596
75
Reg. Dist. No.

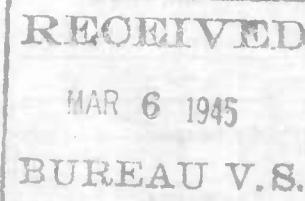
1. PLACE OF DEATH: Carroll
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

3. (a) FULL NAME
John Valentine Wentz
4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife Ellen Tracey Wentz
7. Birth date of deceased (mo., day, yr.) Dec. 16, 1850 6. (c) If alive, give age years
8. AGE: Years Months Days If less than one day
94 1 22 hrs. min.
9. Birthplace York Co., Penna.
(Town, county, and state)
10. Usual occupation Retired
11. Industry or business
12. Name Abdel P. Wentz
13. Birthplace York Co., Penna.
14. Maiden name Mandille Wolfgang
15. Birthplace Carroll Co., Md.
16. Informant H. T. Wentz
Address Manchester Md
17. Burial Lazarus Union Cemetery Date thereof Feb. 12, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory
Location Lineboro, Md.
18. Funeral director H. C. Geippl
Address Glen Rock, Penna.
19. (Date rec'd by registrar) Feb. 10/45 9/10/45 H. P. S. Denner
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
Md. Carroll
State..... County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION
Feb. 8, 1945 4 P.M.
20. DATE OF DEATH
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Visited the body after 19
and that I last saw h. alive on 19
Immediate cause of death Coronary & thrombosis
DURATION 2 hours
Due to
Due to
Other conditions
(Include pregnancy within 8 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE S. M. Kash. M.D.
M. D. or other
Address Hampton Rd. Date signed 2/10/45



Don Nash

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 134

01597

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH

Carroll
County

City or town Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months, 22 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.

How long in hospital or institution?

3. (a) FULL NAME

SIRANDAL WILCOX

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female col.

married

8. (b) Name of husband or wife

Gerard Wilcox

7. Birth date of deceased

(mo., day, yr.)

July 10, 1920

6. (c) If alive, give age

26

years

8. AGE:

Years

Months

Days

If less than one day

24

7

2

.....hrs.

.....min.

9. Birthplace

Edesville, Maryland

(Town, county, and state)

10. Usual occupation

Defense Worker

11. Industry or business

FATHER

12. Name Alfred Thomas

MOTHER

13. Birthplace Unknown

MOTHER

14. Maiden name Fannie Golden

15. Birthplace

Edesville, Maryland

16. Informant

Reuben Hoffman, M.D.

Address

Henryton, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

2/15/45
(month) (day) (year)

Cemetery or crematory

Eden

Location

Rock Hall, Kent Co. Md.

18. Funeral director

Maurice W. Williams

Address

Chester, Maryland

Feb. 12, 1945

(Date rec'd by registrar)

Albert R. Swankham

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent

City or town Chestertown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 202 College Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH February 12, 1945, at 7:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 21, 1944, to Feb. 12, 1945.

and that I last saw her alive on February 12, 1945.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

May 1, 1944

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

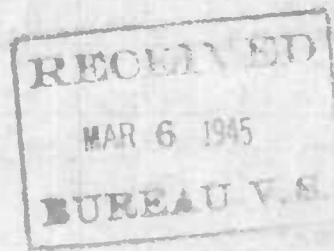
Injured at work?

23. SIGNATURE

Reuben Hoffman, M.D.

M. D. or other

Address Henryton, Maryland Date signed 2-12-45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1700

01598

CERTIFICATE OF DEATH

Reg. Dist. No. 82

1. PLACE OF DEATH: Carroll
 County
 City or town Rural ---Mt. Airy,
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 Maryland Carroll
 State
 City or town Rural --- Mt. Airy
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R.D. Mt. Airy
 (If rural, give LOCATION)

3. (a) FULL NAME
 Raymond Williams

4. Sex Male	5. Color or race Colored	6. (a) Single, married, widowed, or divorced Single
-------------	--------------------------	---

6. (b) Name of husband or wife.....
 7. Birth date of deceased (mo., day, yr.) July 4, 1889
 8. AGE: Years Months Days It less than one day

45	7	7 hrs. min.
----	---	---	------------	------------

9. Birthplace Frederick Co. Md.
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Daniel Williams

MOTHER FATHER 12. Name..... Maryland

13. Birthplace Maryland

14. Maiden name..... Lucille V. Ryan

15. Birthplace Maryland

16. Informant Mrs. Lucille V. Williams

Address Mt. Airy, Md.

17. Burial Date thereof 2-14-45
 (Burial, cremation, or removal. When?) (month) (day) (year)

Cemetery or crematory Mt. Zion

Location near Mt. Airy, Carroll Co. Md.

18. Funeral director C. M. Waltz

Address Winfield, Md.

19. Feb. 1945 The D. Snyder
 (Date rec'd by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11, 1945 at 12:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. 10. 19. t9.

and that I last saw h. alive on 19.

Immediate cause of death

Brokes neck - fractured spine

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

Physician: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? Mt. Airy, Carroll, Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Route # 27

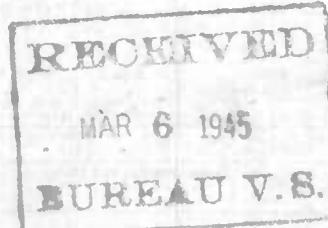
Means of injury Struck by automobile Injured at work? No.

23. SIGNATURES: Please sign and affix to this certificate. Deputy Medical Examiner

M. D. or other

Address New Windsor, Md. Date signed Feb. 11, 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

01599

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
Carroll
County.....

City or town..... Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 5 months, 6 days

Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium

Colored Branch, Henryton, Md.

How long in hospital or institution?.....

3. (a) FULL NAME
IRENE JEANETTE WILLOUGHBY

4. Sex..... female
5. Color or race..... colored
6. (a) Single, married, widowed, or divorced..... married

6. (b) Name of husband or wife..... Richard Willoughby

6. (c) If alive, give age..... 21 years
7. Birth date of deceased (mo., day, yr.)..... March 16, 1924

8. AGE: Years..... 20
Months..... 10
Days..... 22
If less than one day..... hrs. min.

9. Birthplace..... Baltimore, Md.
(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business..... at home

12. Name..... Louis Johnson

13. Birthplace..... Lancaster County, Virginia

14. Maiden name..... Nora Johnson

15. Birthplace..... Northumberland Co., Va.

16. Informant..... Reuben Hoffman, M. D.

Address..... Henryton, Md.

17. Burial..... Burial
(Burial, cremation, or removal. Which?) Date thereof..... Rel. 19-45
(month) (day) (year)

Cemetery or crematory..... Mt Calvary

Location..... Rockland, Co.

18. Funeral director..... Geo. G. Kelson

Address..... 1303 Preston

19. 2/7..... 45..... 19..... Deputy Local..... Registrar
(Date rec'd by registrar) (Date) (Year) (Title) (Signature)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland
County..... Baltimore

City or town..... (If outside city or town limits, write RURAL and give nearest town)

Street No..... 1402 Madison Ave.,
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

Lost

MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 7, 1945, at 2.45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept., 1, 1944, to Feb., 7, 1945, and that I last saw her alive on February 7, 1945.

Immediate cause of death.....

Pulmonary Tuberculosis

DURATION

July 15, 1944

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

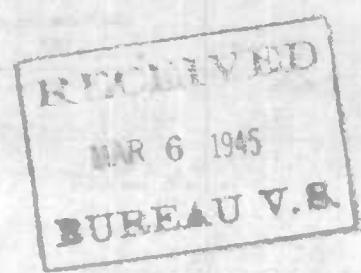
Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Reuben Hoffman, M.D.

M. D. or other

Address..... Henryton, Md. Date signed..... 2/7/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 136

01690

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH:

County..... Carroll
City or town..... Henryton, Md.

(If outside city or town limits, write RURAL and give nearest town)

3 months, 5 days

How long in above place of death?

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Charles

City or town..... La Plata

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

DOROTHY LUCILLE WILLS

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife.....

7. Birth date of
deceased (mo., day, yr.) July 4, 1922

8. AGE: Years Months Days If less than one day
22 6 28 hrs. min.

9. Birthplace..... Bel Alton, Md.
(Town, county, and state)

10. Usual occupation..... Worker in tobacco factory

11. Industry or business.....

12. Name..... Johnny Wills

13. Birthplace..... Unknown

14. Maiden name..... Elizabeth Garner

15. Birthplace..... Unknown

16. Informant..... Reuben Hoffman, M.D.

Address..... Henryton, Maryland

17. Burial..... Date thereof..... Feb 5 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory..... St Ignatius

Location..... Bel Alton, Md

18. Funeral director..... Hunt & Tyson

Address..... Waldeym

19. Feb. 1, 1945 Albert R. Swank
(Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 1, 1945, at 12:05 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
October 27, 1944, Feb. 1, 1945
and that I last saw him alive on February 1, 1945

Immediate cause of death.....

Pulmonary Tuberculosis

DURATION

June 1944

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

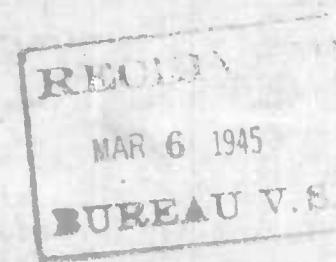
23. SIGNATURE

Reuben Hoffman, M.D.

M. D. or other

2-1-45

Date signed.....



M

MARGIN RESERVED FOR BINDING

1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131-2

01691

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County

City or town

Carroll

Lykensville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

3 mos 3 da

Hospital, institution, or street address where death occurred

Springfield State Hospital

How long in hospital or institution?

5 mos 4 da

3. (a) FULL NAME

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

divorced

6. (b) Name of husband or wife

Guy Wilson

7. Birth date of deceased (mo., day, yr.)

Feb 13th 1880

(If alive, give age)

years

8. AGE:

Years
65Months
10Days
If less than one dayhrs.
min.

8. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

11. Industry or business

Abraham Hayden

12. Name

Abraham Hayden

13. Birthplace

Maryland

14. Maiden name

Lucy Downs

15. Birthplace

Maryland

16. Burial

Burial

(Burial, cremation, or removal. Which?)

Date thereof
(month) (day) (year)Date thereof
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Springfield Methodist

Location

Lykensville, Md.

18. Funeral director

C. Harry Wilson

Address

Lykensville, Md.

19. Date rec'd by registrar

Mar. 1 1945

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

City or town

Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.

2317 W North Ave

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 23d 1945 at 7-15 P.M.

21. I CERTIFY that death occurred on the date above stated; that Lavender deceased from

Sept 19th 1944 to Feb 23 1945
and that I last saw her alive on Feb 23 1945

Immediate cause of death

Chronic Myocarditis

DURATION

Due to

Ch. Intestine

10 yrs

Due to

Myocarditis

5 yrs

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. F. Martin M.D.

M. D. or other

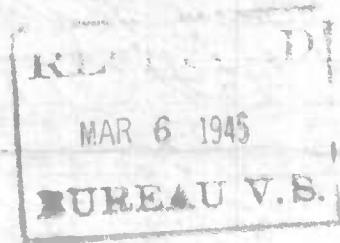
Address

Lykensville

Date signed 2-24-45

VS A15

T



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4702

01602

Reg. Dist. No. 24

CERTIFICATE OF DEATH

1. PLACE OF DEATH: Carroll
County.....
City or town..... rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years, 1 month
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 3 years, 1 month

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County.....
City or town..... Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3125 Mareco Avenue
(If rural, give LOCATION)

3. (a) FULL NAME
Richard Wissner

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced
male white married

6. (b) Name of husband or wife.....
Gertrude Caroline Snyder
..... 6. (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) January 7, 1886

8. AGE: Years Months Days If less than one day
59 1 1 hrs. min.

9. Birthplace.....
Baltimore City, Maryland
(Town, county, and state)

10. Usual occupation.....
Cooperman

11. Industry or business.....
Railroad warehouse

12. Name.....
John Wissner

13. Birthplace.....
Germany

14. Maiden name.....
Mary Catherine Kolb

15. Birthplace.....
Baltimore City, Maryland

16. Informant.....
Springfield State Hosp. records

Address.....
Sykesville, Maryland

17. Burial.....
(Burial, cremation, or removal. Which?)
Date thereof (month) (day) (year)
Feb. 10, 1945

Cemetery or crematory.....
Baltimore Cemetery

Location.....
Baltimore Md.

18. Funeral director.....
Joseph Bertrand

Address.....
Greenmount Ave., Baltimore

Date rec'd by registrar.....
Feb. 8, 1945 C. Harry New

MEDICAL CERTIFICATION
20. DATE OF DEATH..... February 8 1945 at 12:35 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943 to Feb. 8 1945
and that I last saw him alive on February 8 1945

Immediate cause of death.....
Bronchogenic carcinoma
DURATION
1 year

Due to.....
Arteriosclerosis and hypertension, prior to 1942

Other conditions.....
Involutional psychosis, melancholia
(Include pregnancy within 3 months of death)
4 yrs.

Major findings of operations.....
Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury..... Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE..... Robert Bertrand May, M.D. or other
Springfield State Hospital M.D. or other
Sykesville, Maryland Date signed 2-8-45
Address.....

RECEIVED

MAR 6 1945

BUREAU